

# Senate File 2390 - Introduced

SENATE FILE \_\_\_\_\_  
BY COMMITTEE ON HUMAN  
RESOURCES

(SUCCESSOR TO SSB 3140)

Passed Senate, Date \_\_\_\_\_ Passed House, Date \_\_\_\_\_  
Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_ Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_  
Approved \_\_\_\_\_

## A BILL FOR

1 An Act relating to health care reform in Iowa including the Iowa  
2 choice health care coverage program; continuation of dependent  
3 health care coverage; the bureau of health insurance  
4 oversight; medical homes; prevention and chronic care  
5 management; the Iowa health information technology system;  
6 long-term living and patient autonomy; health care quality,  
7 consumer information, cost-containment, and health care  
8 access; the certificate of need program; and health care  
9 transparency; and including an applicability provision.  
10 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:  
11 TLSB 6443SV 82  
12 av:pf/rj/8

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1 1 DIVISION I  
1 2 IOWA CHOICE HEALTH CARE COVERAGE PROGRAM  
1 3 Section 1. DECLARATION OF INTENT. It is the intent of the  
1 4 general assembly in enacting this division of this Act, if  
1 5 sufficient funding is available, to progress toward  
1 6 achievement of the goal that all Iowans have health care  
1 7 coverage with the following priorities:  
1 8 1. The goal that all children in the state have qualified  
1 9 health care coverage which meets certain standards of quality  
1 10 and affordability with the following priorities:  
1 11 a. Covering all children who are declared eligible for  
1 12 medical assistance, the state children's health insurance  
1 13 program, and hawk=i no later than January 1, 2011.  
1 14 b. Subsidizing qualified health care coverage which meets  
1 15 certain standards of quality and affordability, for the  
1 16 remaining uninsured children less than nineteen years of age  
1 17 with a family income from two hundred percent to less than  
1 18 three hundred percent of the federal poverty level, under a  
1 19 sliding=scale contribution requirement based on family income  
1 20 no later than January 1, 2011.  
1 21 c. Moving toward a requirement that all parents of  
1 22 children less than nineteen years of age must provide proof of  
1 23 qualified health care coverage which meets certain standards  
1 24 of quality and affordability no later than January 1, 2011.  
1 25 2. The goal of providing unsubsidized options for  
1 26 low-income adult Iowans with family income up to four hundred  
1 27 percent of the federal poverty level to purchase qualified  
1 28 health care coverage which meets certain standards of quality  
1 29 and affordability.  
1 30 3. The goal of decreasing health care costs and health  
1 31 care coverage costs by:  
1 32 a. Instituting health insurance reforms that assure the  
1 33 availability of private health insurance coverage for all  
1 34 Iowans by addressing issues involving guaranteed availability  
1 35 and issuance of insurance to applicants, preexisting condition  
2 1 exclusions, portability, and allowable or required pooling and  
2 2 rating classifications.  
2 3 b. Requiring every child who has public health care  
2 4 coverage under a public program administered by the state or  
2 5 is insured by a plan created by the Iowa choice health care  
2 6 coverage program to have a medical home.  
2 7 c. Establishing a statewide telehealth system.  
2 8 d. Implementing cost containment strategies such as  
2 9 disease management programs, advance medical directives,  
2 10 initiatives such as end-of-life planning, and transparency in

2 11 health care cost and quality information.

2 12 Sec. 2. Section 514E.1, Code 2007, is amended by adding  
2 13 the following new subsections:

2 14 NEW SUBSECTION. 6A. "Eligible individual" means an  
2 15 individual who satisfies the eligibility requirements for  
2 16 participation in the Iowa choice health care coverage program  
2 17 as provided by the association by rule.

2 18 NEW SUBSECTION. 14A. "Iowa choice health care coverage  
2 19 program" means the Iowa choice health care coverage program  
2 20 established in this chapter.

2 21 NEW SUBSECTION. 14B. "Iowa choice health care policy"  
2 22 means an individual or group policy issued by the association  
2 23 that provides the coverage set forth in the benefit plans  
2 24 adopted by the association's board of directors and approved  
2 25 by the commissioner for the Iowa choice health care coverage  
2 26 program.

2 27 NEW SUBSECTION. 14C. "Iowa choice health insurance" means  
2 28 the health insurance product established by the Iowa choice  
2 29 health care coverage program that is offered by a private  
2 30 health insurance carrier.

2 31 NEW SUBSECTION. 14D. "Iowa choice health insurance  
2 32 carrier" means any entity licensed by the division of  
2 33 insurance of the department of commerce to provide health  
2 34 insurance in Iowa or an organized delivery system licensed by  
2 35 the director of public health that has contracted with the  
3 1 association to provide health insurance coverage to eligible  
3 2 individuals under the Iowa choice health care coverage  
3 3 program.

3 4 NEW SUBSECTION. 21. "Qualified health care coverage"  
3 5 means creditable coverage which meets minimum standards of  
3 6 quality and affordability as determined by the association by  
3 7 rule.

3 8 Sec. 3. Section 514E.2, subsections 1 and 3, Code 2007,  
3 9 are amended to read as follows:

3 10 1. The Iowa comprehensive health insurance association is  
3 11 established as a nonprofit corporation. The association shall  
3 12 assure that benefit plans as authorized in section 514E.1,  
3 13 subsection 2, for an association policy, are made available to  
3 14 each eligible Iowa resident and each federally eligible  
3 15 individual applying to the association for coverage. The  
3 16 association shall also be responsible for administering the  
3 17 Iowa individual health benefit reinsurance association  
3 18 pursuant to all of the terms and conditions contained in  
3 19 chapter 513C. The association shall also assure that benefit  
3 20 plans as authorized in section 514E.1, subsection 14C, for an  
3 21 Iowa choice health care policy are made available to each  
3 22 eligible individual applying to the association for coverage.

3 23 a. All carriers and all organized delivery systems  
3 24 licensed by the director of public health providing health  
3 25 insurance or health care services in Iowa, whether on an  
3 26 individual or group basis, and all other insurers designated  
3 27 by the association's board of directors and approved by the  
3 28 commissioner shall be members of the association.

3 29 b. The association shall operate under a plan of operation  
3 30 established and approved under subsection 3 and shall exercise  
3 31 its powers through a board of directors established under this  
3 32 section.

3 33 3. The association shall submit to the commissioner a plan  
3 34 of operation for the association and any amendments necessary  
3 35 or suitable to assure the fair, reasonable, and equitable  
4 1 administration of the association. The plan of operation  
4 2 shall include provisions for the issuance of Iowa choice  
4 3 health care policies and shall include provisions for the  
4 4 implementation of the Iowa choice health care coverage program  
4 5 established in section 514E.5. The plan of operation becomes

4 6 effective upon approval in writing by the commissioner prior  
4 7 to the date on which the coverage under this chapter must be  
4 8 made available. After notice and hearing, the commissioner  
4 9 shall approve the plan of operation if the plan is determined  
4 10 to be suitable to assure the fair, reasonable, and equitable  
4 11 administration of the association, and provides for the  
4 12 sharing of association losses, if any, on an equitable and  
4 13 proportionate basis among the member carriers. If the  
4 14 association fails to submit a suitable plan of operation  
4 15 within one hundred eighty days after the appointment of the  
4 16 board of directors, or if at any later time the association  
4 17 fails to submit suitable amendments to the plan, the  
4 18 commissioner shall adopt, pursuant to chapter 17A, rules  
4 19 necessary to implement this section. The rules shall continue  
4 20 in force until modified by the commissioner or superseded by a  
4 21 plan submitted by the association and approved by the

4 22 commissioner. In addition to other requirements, the plan of  
4 23 operation shall provide for all of the following:  
4 24 a. The handling and accounting of assets and moneys of the  
4 25 association.  
4 26 b. The amount and method of reimbursing members of the  
4 27 board.  
4 28 c. Regular times and places for meeting of the board of  
4 29 directors.  
4 30 d. Records to be kept of all financial transactions, and  
4 31 the annual fiscal reporting to the commissioner.  
4 32 e. Procedures for selecting the board of directors and  
4 33 submitting the selections to the commissioner for approval.  
4 34 f. The periodic advertising of the general availability of  
4 35 health insurance coverage from the association.  
5 1 g. Additional provisions necessary or proper for the  
5 2 execution of the powers and duties of the association.

5 3 Sec. 4. NEW SECTION. 514E.5 IOWA CHOICE HEALTH CARE  
5 4 COVERAGE PROGRAM.

5 5 1. The association shall establish the Iowa choice health  
5 6 care coverage program to provide access to qualified health  
5 7 care coverage to all Iowa children less than nineteen years of  
5 8 age with the following priorities:

5 9 a. As funding becomes available, all children who are  
5 10 declared eligible for medical assistance, the state children's  
5 11 health insurance program, and hawk=i shall be enrolled in such  
5 12 programs no later than January 1, 2011. Implementation of  
5 13 this requirement may include a coverage reporting requirement  
5 14 on Iowa income tax returns or during school registration.

5 15 b. As funding becomes available, all uninsured children  
5 16 less than nineteen years of age with a family income of up to  
5 17 three hundred percent of the federal poverty level, who are  
5 18 not declared eligible for a program under paragraph "a", shall  
5 19 receive a premium subsidy determined using a sliding=scale  
5 20 contribution requirement based on family income as provided in  
5 21 subsection 3, to purchase qualified health care coverage from  
5 22 the Iowa choice health care coverage program no later than  
5 23 January 1, 2011. Implementation of this requirement may  
5 24 include a coverage reporting requirement on Iowa income tax  
5 25 returns or during school registration.

5 26 c. All children less than nineteen years of age shall be  
5 27 required to have qualified health care coverage no later than  
5 28 January 1, 2011. All parents or legal guardians of children  
5 29 less than nineteen years of age may be required to provide  
5 30 proof that each child has qualified health care coverage at a  
5 31 time and in a manner as specified by the association by rule.  
5 32 Implementation of this requirement may include a coverage  
5 33 reporting requirement on Iowa income tax returns or during  
5 34 school registration. This paragraph "c" is not applicable to  
5 35 a child whose parent or legal guardian submits a signed  
6 1 affidavit to the association stating that the requirement to  
6 2 have health care coverage conflicts with a genuine and sincere  
6 3 religious belief.

6 4 2. The association shall define what constitutes qualified  
6 5 health care coverage for children less than nineteen years of  
6 6 age. An Iowa choice health care policy shall provide  
6 7 qualified health care coverage for such children. For the  
6 8 purposes of this definition and for designing Iowa choice  
6 9 health care policies, requirements for coverage and benefits  
6 10 shall include but are not limited to all of the following:

6 11 a. Inpatient hospital services including medical,  
6 12 surgical, intensive care unit, mental health, and substance  
6 13 abuse services.

6 14 b. Nursing care services including skilled nursing  
6 15 facility services.

6 16 c. Outpatient hospital services including emergency room,  
6 17 surgery, lab, and x-ray services and other services.

6 18 d. Physician services, including surgical and medical,  
6 19 office visits, newborn care, well=baby and well=child care,  
6 20 immunizations, urgent care, specialist care, allergy testing  
6 21 and treatment, mental health visits, and substance abuse  
6 22 visits.

6 23 e. Ambulance services.

6 24 f. Physical therapy.

6 25 g. Speech therapy.

6 26 h. Durable medical equipment.

6 27 i. Home health care.

6 28 j. Hospice services.

6 29 k. Prescription drugs.

6 30 l. Dental services including preventive services.

6 31 m. Medically necessary hearing services.

6 32 n. Vision services including corrective lenses.

6 33 o. No underwriting requirements and no preexisting  
6 34 condition exclusions.

6 35 3. The association shall establish a methodology to  
7 1 subsidize qualified health care coverage through the Iowa  
7 2 choice health care coverage program for children less than  
7 3 nineteen years of age with a family income from two hundred  
7 4 percent to less than three hundred percent of the federal  
7 5 poverty level, using a sliding-scale contribution requirement  
7 6 for premiums based on family income. The contribution  
7 7 requirement for premiums shall be an amount that is no more  
7 8 than two percent of family income per each child covered, up  
7 9 to a maximum of six and one-half percent of family income per  
7 10 family. The program shall require a ten dollar copayment for  
7 11 all services received under an Iowa choice health care policy  
7 12 that covers a child who has a family income of more than two  
7 13 hundred percent of the federal poverty level.

7 14 4. The association may develop an Iowa choice health care  
7 15 policy that is available for purchase by adults and families  
7 16 who are not eligible for a public program administered by the  
7 17 state or subsidized coverage and have a family income that is  
7 18 less than four hundred percent of the federal poverty level.  
7 19 An Iowa choice health care policy that is offered for purchase  
7 20 to such adults and families shall include, at a minimum,  
7 21 benefits package options with premiums that do not exceed six  
7 22 and one-half percent of family incomes that are less than four  
7 23 hundred percent of the federal poverty level.

7 24 5. The Iowa choice health care coverage program shall  
7 25 provide for health benefits coverage through private health  
7 26 insurance carriers that apply to the association and meet the  
7 27 qualifications described in this section and any additional  
7 28 qualifications established by rules of the association. The  
7 29 Iowa choice health care program shall provide for the sale of  
7 30 Iowa choice health care policies by licensed insurance  
7 31 producers that apply to the association and meet the  
7 32 qualifications established by rules of the association. The  
7 33 association shall collaborate with potential Iowa choice  
7 34 health insurance carriers to do the following, including but  
7 35 not limited to:

8 1 a. Assure the availability of private qualified health  
8 2 care coverage to all eligible individuals by designing  
8 3 solutions to issues relating to guaranteed issuance of  
8 4 insurance, preexisting condition exclusions, portability, and  
8 5 allowable pooling and rating classifications.

8 6 b. Formulate principles that ensure fair and appropriate  
8 7 practices relating to issues involving individual Iowa choice  
8 8 health care policies such as rescission and preexisting  
8 9 condition clauses, and that provide for a binding third-party  
8 10 review process to resolve disputes related to such issues.

8 11 c. Design affordable, portable Iowa choice health care  
8 12 policies that specifically meet the needs of eligible  
8 13 individuals.

8 14 6. The Iowa choice health care coverage program may  
8 15 administer or contract to administer under section 125 of the  
8 16 Internal Revenue Code plans for employers and employees of  
8 17 employers with ten employees or less participating in the  
8 18 program, including medical expense reimbursement accounts and  
8 19 dependent care reimbursement accounts.

8 20 7. The association may implement initiatives such as  
8 21 uniform health care insurance applications and other  
8 22 standardized administrative procedures that make the purchase  
8 23 of health insurance coverage easier and lower administrative  
8 24 costs.

8 25 8. The association, in administering the Iowa choice  
8 26 health care coverage program, may do any of the following:

8 27 a. Seek and receive any grant funding from the federal  
8 28 government, departments, or agencies of this state, and  
8 29 private foundations.

8 30 b. Contract with professional service firms as may be  
8 31 necessary, and fix their compensation.

8 32 c. Employ persons necessary to carry out the duties of the  
8 33 program.

8 34 d. Design a premium schedule to be published by the  
8 35 association by December 1 of each year, which accounting for  
9 1 maximum pricing in all rating factors with an exception for  
9 2 age, includes the lowest premium on the market for which an  
9 3 individual would be eligible for qualified health care  
9 4 coverage. The schedule shall publish premiums allowing  
9 5 variance for age and rate basis type.

9 6 9. The association shall submit an annual report to the  
9 7 governor and the general assembly at the end of the Iowa  
9 8 choice health care coverage program's fiscal year of all the

9 9 activities of the program including but not limited to  
9 10 membership in the program, the administrative expenses of the  
9 11 program, the extent of coverage, the effect on premiums, the  
9 12 number of covered lives, the number of Iowa choice health care  
9 13 policies issued or renewed, and Iowa choice health care  
9 14 coverage program premiums earned and claims incurred by Iowa  
9 15 choice health insurance carriers offering Iowa choice health  
9 16 care policies. The association shall also report specifically  
9 17 on the impact of the program on the small group and individual  
9 18 health insurance markets and any reduction in the number of  
9 19 uninsured individuals in the state.

9 20 10. The association may grant not more than two six-month  
9 21 extensions of the deadlines established in this section as  
9 22 deemed necessary by the association to promote orderly  
9 23 administration of the program and to facilitate public  
9 24 outreach and information concerning the program.

9 25 11. This chapter shall not be construed, is not intended  
9 26 as, and shall not imply a grant of entitlement for services to  
9 27 persons who are eligible for participation in the Iowa choice  
9 28 health care coverage program based upon eligibility consistent  
9 29 with the requirements of this section. Any state obligation  
9 30 to provide services pursuant to this section is limited to the  
9 31 extent of the funds appropriated or provided for  
9 32 implementation of this section.

9 33 12. Section 514E.7 is not applicable to Iowa choice health  
9 34 care policies issued pursuant to this section.

9 35 Sec. 5. NEW SECTION. 514E.6 IOWA CHOICE HEALTH CARE  
10 1 COVERAGE PROGRAM FUND == APPROPRIATION.

10 2 The Iowa choice health care coverage program fund is  
10 3 created in the state treasury as a separate fund under the  
10 4 control of the association for deposit of any funds for  
10 5 initial operating expenses of the Iowa choice health care  
10 6 coverage program, payments made by employers and individuals,  
10 7 and any funds received from any public or private source. All  
10 8 moneys credited to the fund are appropriated and available to  
10 9 the association to be used for the purposes of the Iowa choice  
10 10 health care coverage program. Notwithstanding section 8.33,  
10 11 any balance in the fund on June 30 of each fiscal year shall  
10 12 not revert to the general fund of the state, but shall be  
10 13 available for the purposes set forth for the program in this  
10 14 chapter in subsequent years.

10 15 Sec. 6. DIRECTIVE TO DEPARTMENT OF HUMAN SERVICES ==  
10 16 EXPANSION OF STATE CHILDREN'S HEALTH INSURANCE COVERAGE. If  
10 17 sufficient funding is available and if federal reauthorization  
10 18 of the state children's health insurance program provides  
10 19 sufficient federal allocations to the state and authorization  
10 20 to cover such children as an option under the state children's  
10 21 health insurance program, the department shall expand coverage  
10 22 under the state children's health insurance program to cover  
10 23 children with family incomes up to three hundred percent of  
10 24 the federal poverty level.

10 25 DIVISION II  
10 26 CONTINUATION OF DEPENDENT  
10 27 HEALTH CARE COVERAGE

10 28 Sec. 7. Section 509.3, Code 2007, is amended by adding the  
10 29 following new subsection:

10 30 NEW SUBSECTION. 8. A provision that the insurer will  
10 31 permit continuation of existing coverage for an unmarried  
10 32 dependent child of an insured or enrollee who so elects, at  
10 33 least through the age of twenty-five years old or so long as  
10 34 the dependent child maintains full-time status as a student in  
10 35 an accredited institution of postsecondary education,  
11 1 whichever occurs last, at a premium established in accordance  
11 2 with the insurer's rating practices.

11 3 Sec. 8. NEW SECTION. 514A.3B CONTINUATION OF DEPENDENT  
11 4 COVERAGE REQUIREMENT.

11 5 An insurer issuing an individual policy or contract of  
11 6 accident and health insurance which provides coverage for  
11 7 dependent children of the insured shall permit continuation of  
11 8 existing coverage for an unmarried dependent child of an  
11 9 insured or enrollee who so elects, at least through the age of  
11 10 twenty-five years old or so long as the dependent child  
11 11 maintains full-time status as a student in an accredited  
11 12 institution of postsecondary education, whichever occurs last,  
11 13 at a premium established in accordance with the insurer's  
11 14 rating practices.

11 15 Sec. 9. APPLICABILITY. This division of this Act applies  
11 16 to policies or contracts of accident and health insurance  
11 17 delivered or issued for delivery or continued or renewed in  
11 18 this state on or after July 1, 2008.

11 19 DIVISION III

BUREAU OF HEALTH INSURANCE OVERSIGHT

11 20  
11 21 Sec. 10. NEW SECTION. 505.8A BUREAU OF HEALTH INSURANCE  
11 22 OVERSIGHT.

11 23 1. The bureau of health insurance oversight is created in  
11 24 the insurance division of the department of commerce to  
11 25 promote uniformity and transparency in the administrative and  
11 26 operational business requirements and practices that are  
11 27 imposed by health insurers upon health care providers for the  
11 28 purpose of maximizing administrative efficiencies and  
11 29 minimizing administrative costs of health care providers that  
11 30 contract with or otherwise have business relationships with  
11 31 health insurers.

11 32 2. The bureau of health insurance oversight shall have  
11 33 jurisdiction over administrative and operational policies,  
11 34 processes, and practices of health insurers that are imposed  
11 35 upon or otherwise affect health care providers, including but  
12 1 not limited to eligibility determinations; coordination of  
12 2 benefits; claims administration; noncompliance with contract  
12 3 terms and conditions; preauthorization, notification, or  
12 4 accreditation programming; notice to providers; and sanctions.

12 5 3. The commissioner of insurance shall establish a process  
12 6 for the filing, receipt, and investigation of complaints by  
12 7 health care providers regarding administrative and operational  
12 8 requirements and practices of health insurers that impede  
12 9 administrative efficiency, add administrative costs, or  
12 10 otherwise impair the provider's ability to provide affordable,  
12 11 quality health care services. For purposes of this section,  
12 12 complaints may be filed on behalf of such providers by a  
12 13 professional society that advocates on behalf of the interests  
12 14 of their provider members.

12 15 4. The commissioner shall require health insurers to file  
12 16 with the bureau of health insurance oversight each contract  
12 17 the insurer offers to health care providers in this state, at  
12 18 least ninety days prior to offering that contract to a health  
12 19 care provider. The filed contracts shall be accessible to the  
12 20 public upon request.

12 21 5. The commissioner may, from time to time, convene  
12 22 representatives of health insurers, health care providers, and  
12 23 other interested persons, to discuss administrative or  
12 24 operational policies, processes, or practices of health  
12 25 insurers that affect health care providers and to recommend  
12 26 ways to improve upon such policies, processes, or practices to  
12 27 foster uniformity and transparency and to minimize  
12 28 administrative costs to health care providers.

12 29 6. The commissioner shall identify administrative and  
12 30 operational policies, processes, or practices that merit  
12 31 regulatory intervention or direction by the commissioner and  
12 32 shall take action as appropriate within the commissioner's  
12 33 authority to effectuate the purposes of this section.

12 34 7. The commissioner may make recommendations to the  
12 35 general assembly and the governor regarding legislation  
13 1 affecting health insurers' administrative and operational  
13 2 business requirements and practices imposed upon health care  
13 3 providers for the purpose of furthering uniformity, advancing  
13 4 health insurer transparency of such requirements and  
13 5 practices, and lessening administrative costs to health care  
13 6 providers.

13 7 8. The commissioner shall adopt rules under chapter 17A as  
13 8 necessary to carry out the provisions of this section.

13 9 9. As used in this section, unless the context requires  
13 10 otherwise:

13 11 a. "Health care provider" means a physician licensed under  
13 12 chapter 148, 150, or 150A.

13 13 b. "Health insurer" means any entity which provides a  
13 14 health benefit plan.

13 15 DIVISION IV  
13 16 MEDICAL HOME  
13 17 DIVISION XXI  
13 18 MEDICAL HOME

13 19 Sec. 11. NEW SECTION. 135.154 DEFINITIONS.

13 20 As used in this chapter, unless the context otherwise  
13 21 requires:

13 22 1. "Department" means the department of public health.

13 23 2. "Health care professional" means a person who is  
13 24 licensed, certified, or otherwise authorized or permitted by  
13 25 the laws of this state to administer health care in the  
13 26 ordinary course of business or in the practice of a  
13 27 profession.

13 28 3. "Medical home" means a team approach to providing  
13 29 health care that originates in a primary care setting; fosters  
13 30 a partnership among the patient, the primary care physician

13 31 and other health care professionals, and where appropriate,  
13 32 the patient's family; utilizes the partnership to access all  
13 33 medical and nonmedical health-related services needed by the  
13 34 patient and the patient's family to achieve maximum health  
13 35 potential; maintains a centralized, comprehensive record of  
14 1 all health-related services to promote continuity of care; and  
14 2 has all of the characteristics specified in section 135.155.

14 3 4. "Medical home commission" or "commission" means the  
14 4 medical home commission created in section 135.156.

14 5 5. "National committee for quality assurance" means the  
14 6 nationally recognized, independent nonprofit organization that  
14 7 measures the quality and performance of health care and health  
14 8 care plans in the United States; provides accreditation,  
14 9 certification, and recognition programs for health care plans  
14 10 and programs; and is recognized in Iowa as an accrediting  
14 11 organization for commercial and Medicaid-managed care  
14 12 organizations.

14 13 6. "Nonphysician primary care professionals" means  
14 14 providers of health care other than physicians who render some  
14 15 primary care services including pharmacists, nurse  
14 16 practitioners, physician assistants, and other health care  
14 17 professionals.

14 18 7. "Personal provider" means the patient's first point of  
14 19 contact in the health care system with a primary care provider  
14 20 who identifies the patient's health needs, and, working with a  
14 21 team of health care professionals, provides for and  
14 22 coordinates appropriate care to address the health needs  
14 23 identified.

14 24 8. "Primary care" means health care which emphasizes  
14 25 providing for a patient's general health needs and utilizes  
14 26 collaboration with other health care professionals and  
14 27 consultation or referral as appropriate to meet the needs  
14 28 identified. "Primary care" is usually provided by general and  
14 29 family practitioners, internists, obstetricians,  
14 30 pediatricians, and certain nonprimary care professionals who  
14 31 are specifically trained for and skilled in comprehensive  
14 32 first contact and continuing care for persons with any  
14 33 undiagnosed sign, symptom, or health concern not limited by  
14 34 problem origin, organ system, or diagnosis. "Primary care"  
14 35 includes health promotion, disease prevention, health  
15 1 maintenance, counseling, patient education, and diagnosis and  
15 2 treatment of acute and chronic illnesses. "Primary care" also  
15 3 provides patient advocacy in the health care system to  
15 4 accomplish cost-effective care through coordination of health  
15 5 care services, promotion of effective communication with  
15 6 patients, and encouragement of the role of the patient as a  
15 7 partner in health care.

15 8 9. "Primary care physician" means a generalist physician  
15 9 who is specifically trained to provide primary care at the  
15 10 point of first contact, and takes continuing responsibility  
15 11 for providing the patient's care.

15 12 Sec. 12. NEW SECTION. 135.155 MEDICAL HOME PURPOSES ==  
15 13 CHARACTERISTICS.

15 14 1. The purposes of a medical home are the following:

15 15 a. To reduce disparities in health care access, delivery,  
15 16 and health care outcomes.

15 17 b. To improve quality of health care and lower health care  
15 18 costs, thereby creating savings to allow more Iowans to have  
15 19 health care coverage and to provide for the sustainability of  
15 20 the health care system.

15 21 c. To provide a tangible method to document if each Iowan  
15 22 has access to health care.

15 23 2. A medical home has all of the following  
15 24 characteristics:

15 25 a. A personal provider. Each patient has an ongoing  
15 26 relationship with a personal provider trained to provide first  
15 27 contact and continuous and comprehensive care.

15 28 b. A provider-directed medical practice. The personal  
15 29 provider leads a team of individuals at the practice level who  
15 30 collectively take responsibility for the ongoing health care  
15 31 of patients.

15 32 c. Whole person orientation. The personal provider and  
15 33 team are responsible for ensuring that all of the patient's  
15 34 health care needs are met through direct provision of services  
15 35 or by appropriately arranging for health care by other  
16 1 qualified health care professionals. This responsibility  
16 2 includes health care at all stages of life including provision  
16 3 of acute care, chronic care, preventive services, and  
16 4 end-of-life care.

16 5 d. Coordination and integration of care. Care is  
16 6 coordinated and integrated across all elements of the complex

16 7 health care system and the patient's community. Care is  
16 8 facilitated by registries, information technology, health  
16 9 information exchanges, and other means to assure that patients  
16 10 get the indicated care when and where they need and want the  
16 11 care in a culturally and linguistically appropriate manner.  
16 12 e. Quality and safety. The following are quality and  
16 13 safety components of the medical home:  
16 14 (1) Provider-directed medical practices advocate for their  
16 15 patients to support the attainment of optimal,  
16 16 patient-centered outcomes that are defined by a care planning  
16 17 process driven by a compassionate, robust partnership between  
16 18 providers, the patient, and the patient's family.  
16 19 (2) Evidence-based medicine and clinical decision-support  
16 20 tools guide decision making.  
16 21 (3) Providers in the medical practice accept  
16 22 accountability for continuous quality improvement through  
16 23 voluntary engagement in performance measurement and  
16 24 improvement.  
16 25 (4) Patients actively participate in decision making and  
16 26 feedback is sought to ensure that the patients' expectations  
16 27 are being met.  
16 28 (5) Information technology is utilized appropriately to  
16 29 support optimal patient care, performance measurement, patient  
16 30 education, and enhanced communication.  
16 31 (6) Practices participate in a voluntary recognition  
16 32 process conducted by an appropriate nongovernmental entity to  
16 33 demonstrate that the practice has the capabilities to provide  
16 34 patient-centered services consistent with the medical home  
16 35 model.  
17 1 (7) Patients and families participate in quality  
17 2 improvement activities at the practice level.  
17 3 f. Enhanced access to health care. Enhanced access to  
17 4 health care is available through systems such as open  
17 5 scheduling, expanded hours, and new options for communication  
17 6 between the patient, the patient's personal provider, and  
17 7 practice staff.  
17 8 g. Payment. The payment system appropriately recognizes  
17 9 the added value provided to patients who have a  
17 10 patient-centered medical home. The payment structure  
17 11 framework of the medical home provides all of the following:  
17 12 (1) Reflects the value of provider and nonprovider staff  
17 13 and patient-centered care management work that is in addition  
17 14 to the face-to-face visit.  
17 15 (2) Pays for services associated with coordination of  
17 16 health care both within a given practice and between  
17 17 consultants, ancillary providers, and community resources.  
17 18 (3) Supports adoption and use of health information  
17 19 technology for quality improvement.  
17 20 (4) Supports provision of enhanced communication access  
17 21 such as secure electronic mail and telephone consultation.  
17 22 (5) Recognizes the value of physician work associated with  
17 23 remote monitoring of clinical data using technology.  
17 24 (6) Allows for separate fee-for-service payments for  
17 25 face-to-face visits. Payments for health care management  
17 26 services that are in addition to the face-to-face visit do not  
17 27 result in a reduction in the payments for face-to-face visits.  
17 28 (7) Recognizes case mix differences in the patient  
17 29 population being treated within the practice.  
17 30 (8) Allows providers to share in savings from reduced  
17 31 hospitalizations associated with provider-guided health care  
17 32 management in the office setting.  
17 33 (9) Allows for additional payments for achieving  
17 34 measurable and continuous quality improvements.  
17 35 Sec. 13. NEW SECTION. 135.156 MEDICAL HOME COMMISSION.  
18 1 1. A medical home commission is created consisting of the  
18 2 following members:  
18 3 a. The director of public health, or the director's  
18 4 designee, who shall act as chairperson of the commission.  
18 5 b. The director of human services, or the director's  
18 6 designee.  
18 7 c. The commissioner of insurance, or the commissioner's  
18 8 designee.  
18 9 d. A representative of health insurers.  
18 10 e. A representative of the Iowa dental association.  
18 11 f. A representative of the Iowa nurses association.  
18 12 g. A family physician who is a member of the Iowa academy  
18 13 of family physicians.  
18 14 h. A health care consumer.  
18 15 i. A representative of the Iowa collaborative safety net  
18 16 provider network established pursuant to section 135.153.  
18 17 j. A representative of the Iowa pharmacy association.

18 18 k. A representative of the Iowa osteopathic association.  
18 19 1. A representative of the Iowa chiropractic society.  
18 20 2. a. Members of the commission from the organizations  
18 21 specified in subsection 1 shall be selected by the respective  
18 22 organization. Terms of public members of the commission shall  
18 23 begin and end as provided by section 69.19. Any vacancy shall  
18 24 be filled in the same manner as regular appointments are made  
18 25 for the unexpired portion of the regular term. Public members  
18 26 shall serve terms of three years. A member is eligible for  
18 27 reappointment for two successive terms.  
18 28 b. Public members of the commission shall receive their  
18 29 actual and necessary expenses incurred in the performance of  
18 30 their duties and may be eligible to receive compensation as  
18 31 provided in section 7E.6.  
18 32 c. The commission shall meet at least quarterly and in  
18 33 accordance with rules adopted by the commission.  
18 34 d. A majority of the members of the commission constitutes  
18 35 a quorum. Any action taken by the commission must be adopted  
19 1 by the affirmative vote of a majority of its voting  
19 2 membership.  
19 3 e. The commission is located for administrative purposes  
19 4 within the division of health promotion and chronic disease  
19 5 management within the department. The commission shall  
19 6 coordinate efforts with other divisions, bureaus, and offices  
19 7 within the department including but not limited to the office  
19 8 of multicultural health established in section 135.12 and oral  
19 9 health bureau established in section 135.15, in order to avoid  
19 10 duplication of efforts. The department shall provide office  
19 11 space, staff assistance, administrative support, and necessary  
19 12 supplies and equipment to the commission.  
19 13 3. The commission may adopt rules pursuant to chapter 17A  
19 14 to administer the programs of the commission.  
19 15 Sec. 14. NEW SECTION. 135.157 MEDICAL HOME SYSTEM ==  
19 16 DEVELOPMENT AND IMPLEMENTATION.  
19 17 1. The commission shall develop a plan for implementation  
19 18 of a statewide medical home system. The commission, in  
19 19 collaboration with parents, schools, communities, health  
19 20 plans, and providers, shall endeavor to increase healthy  
19 21 outcomes for children and adults by linking the children and  
19 22 adults with a medical home, identifying health improvement  
19 23 goals for children and adults, and linking reimbursement  
19 24 strategies to increasing healthy outcomes for children and  
19 25 adults. The plan shall provide that the medical home system  
19 26 shall do all of the following:  
19 27 a. Coordinate and provide access to evidence-based health  
19 28 care services, emphasizing convenient, comprehensive primary  
19 29 care and including preventive, screening, and well-child  
19 30 health services.  
19 31 b. Provide access to appropriate specialty care and  
19 32 in-patient services.  
19 33 c. Provide quality-driven and cost-effective health care.  
19 34 d. Provide access to pharmacist-delivered medication  
19 35 reconciliation and medication therapy management services,  
20 1 where appropriate.  
20 2 e. Promote strong and effective medical management  
20 3 including but not limited to planning treatment strategies,  
20 4 monitoring health outcomes and resource use, sharing  
20 5 information, and organizing care to avoid duplication of  
20 6 service.  
20 7 f. Emphasize patient and provider accountability.  
20 8 g. Prioritize local access to the continuum of health care  
20 9 services in the most appropriate setting.  
20 10 h. Establish a baseline for medical home goals and  
20 11 establish performance measures that indicate a child or adult  
20 12 has an established and effective medical home. For children,  
20 13 these goals and performance measures may include but are not  
20 14 limited to childhood immunization rates, well-child care  
20 15 utilization rates, care management for children with chronic  
20 16 illnesses, emergency room utilization, and oral health service  
20 17 utilization.  
20 18 i. For children, coordinate with and integrate guidelines,  
20 19 data, and information from existing newborn and child health  
20 20 programs and entities, including but not limited to the  
20 21 healthy opportunities to experience success=healthy families  
20 22 Iowa program, the community empowerment program, the center  
20 23 for congenital and inherited disorders screening and health  
20 24 care programs, standards of care for pediatric health  
20 25 guidelines, the office of multicultural health established in  
20 26 section 135.12, the oral health bureau established in section  
20 27 135.15, and other similar programs and services.  
20 28 2. The commission shall develop an organizational

20 29 structure for the medical home system in this state. The  
20 30 organizational structure plan shall integrate existing  
20 31 resources, provide a strategy to coordinate health care  
20 32 services, provide for monitoring and data collection on  
20 33 medical homes, provide for training and education to health  
20 34 care professionals and families, and provide for transition of  
20 35 children to the adult medical care system. The organizational  
21 1 structure may be based on collaborative teams of stakeholders  
21 2 throughout the state such as local public health agencies, the  
21 3 collaborative safety net provider network established in  
21 4 section 135.153, or a combination of statewide organizations.  
21 5 Care coordination may be provided through regional offices or  
21 6 through individual provider practices. The organizational  
21 7 structure may also include the use of telemedicine resources,  
21 8 and may provide for partnering with pediatric and family  
21 9 practice residency programs to improve access to preventive  
21 10 care for children. The organizational structure shall also  
21 11 address the need to organize and provide health care to  
21 12 increase accessibility for patients including using venues  
21 13 more accessible to patients and having hours of operation that  
21 14 are conducive to the population served.

21 15 3. The commission shall adopt standards and a process to  
21 16 certify medical homes based on the national committee for  
21 17 quality assurance standards. The certification process and  
21 18 standards shall provide mechanisms to monitor performance and  
21 19 to evaluate, promote, and improve the quality of health of and  
21 20 health care delivered to patients through a medical home. The  
21 21 mechanism shall require participating providers to monitor  
21 22 clinical progress and performance in meeting applicable  
21 23 standards and to provide information in a form and manner  
21 24 specified by the commission. The evaluation mechanism shall  
21 25 be developed with input from consumers, providers, and payers.  
21 26 At a minimum the evaluation shall determine any increased  
21 27 quality in health care provided and any decrease in cost  
21 28 resulting from the medical home system compared with other  
21 29 health care delivery systems. The standards and process shall  
21 30 also include a mechanism for other ancillary service providers  
21 31 to become affiliated with a certified medical home.

21 32 4. The commission shall adopt education and training  
21 33 standards for health care professionals participating in the  
21 34 medical home system.

21 35 5. The commission shall provide for system simplification  
22 1 through the use of universal referral forms, internet-based  
22 2 tools for providers, and a central medical home internet site  
22 3 for providers.

22 4 6. The commission shall recommend a reimbursement  
22 5 methodology and incentives for participation in the medical  
22 6 home system to ensure that providers enter and remain  
22 7 participating in the system. In developing the  
22 8 recommendations for incentives, the commission shall consider,  
22 9 at a minimum, providing incentives to promote wellness,  
22 10 prevention, chronic care management, immunizations, health  
22 11 care management, and the use of electronic health records. In  
22 12 developing the recommendations for the reimbursement  
22 13 methodology and incentives, the commission shall analyze, at a  
22 14 minimum, the feasibility of all of the following:

22 15 a. Reimbursement under the medical assistance program to  
22 16 promote wellness and prevention, provide care coordination,  
22 17 and provide chronic care management.

22 18 b. Increasing reimbursement to Medicare levels for certain  
22 19 wellness and prevention services, chronic care management, and  
22 20 immunizations.

22 21 c. Providing reimbursement for primary care services by  
22 22 addressing the disparities between reimbursement for specialty  
22 23 services and primary care services.

22 24 d. Increased funding for efforts to transform medical  
22 25 practices into certified medical homes, including emphasizing  
22 26 the implementation of the use of electronic health records.

22 27 e. Targeted reimbursement to providers linked to health  
22 28 care quality improvement measures established by the  
22 29 commission.

22 30 f. Reimbursement for specified ancillary support services  
22 31 such as transportation for medical appointments and other such  
22 32 services.

22 33 g. Providing reimbursement for medication reconciliation  
22 34 and medication therapy management services, where appropriate.

22 35 7. The commission shall coordinate the requirements and  
23 1 activities of the medical home system with the requirements  
23 2 and activities of the dental home for children as described in  
23 3 section 249J.14, subsection 7, and shall recommend financial  
23 4 incentives for dentists and nondental providers to promote

23 5 oral health care coordination through preventive dental  
23 6 intervention, early identification of oral disease risk,  
23 7 health care coordination and data tracking, treatment, chronic  
23 8 care management, education and training, parental guidance,  
23 9 and oral health promotions for children.

23 10 8. The commission shall integrate the recommendations and  
23 11 policies developed by the prevention and chronic care  
23 12 management advisory council into the medical home system.

23 13 9. Implementation phases.

23 14 a. Initial implementation shall require participation in  
23 15 the medical home system of children who are recipients of the  
23 16 medical assistance program and children who have health  
23 17 insurance coverage through the Iowa choice health care  
23 18 coverage program created in section 514E.5. The commission  
23 19 shall work with the department of human services and shall  
23 20 recommend to the general assembly a reimbursement methodology  
23 21 to compensate providers participating under the medical  
23 22 assistance program for participation in the medical home  
23 23 system. The commission shall work with the Iowa choice health  
23 24 care coverage program to develop an enhanced reimbursement  
23 25 methodology for children covered through the program to  
23 26 compensate providers who participate in the medical home  
23 27 system.

23 28 b. The commission shall work with the department of human  
23 29 services and with the Iowa choice health care coverage program  
23 30 to expand the medical home system to adult recipients of  
23 31 medical assistance, the expansion population under the  
23 32 IowaCare program, and adults covered through the Iowa choice  
23 33 health care coverage program. The commission shall work with  
23 34 the centers for Medicare and Medicaid services of the United  
23 35 States department of health and human services to allow

24 1 Medicare recipients to utilize the medical home system.  
24 2 c. The commission shall work with the department of  
24 3 administrative services to allow state employees to utilize  
24 4 the medical home system.

24 5 d. The commission shall work with insurers and  
24 6 self-insured companies, if requested, to make the medical home  
24 7 system available to individuals with private health care  
24 8 coverage.

24 9 10. The commission shall provide oversight for all  
24 10 certified medical homes. The commission shall review the  
24 11 progress of the medical home system at each meeting and  
24 12 recommend improvements to the system, as necessary.

24 13 11. The commission shall annually evaluate the medical  
24 14 home system and make recommendations to the governor and the  
24 15 general assembly regarding improvements to and continuation of  
24 16 the system.

24 17 Sec. 15. Section 249J.14, subsection 7, Code 2007, is  
24 18 amended to read as follows:

24 19 7. DENTAL HOME FOR CHILDREN. By ~~July 1, 2008~~ December 31,

24 20 2010, every recipient of medical assistance who is a child  
24 21 twelve years of age or younger shall have a designated dental  
24 22 home and shall be provided with the dental screenings, ~~and~~  
24 23 ~~preventive care identified in the oral health standards~~  
24 24 ~~services, diagnostic services, treatment services, and~~  
24 25 ~~emergency services as defined under the early and periodic~~  
24 26 screening, diagnostic, and treatment program.

24 27 DIVISION V

24 28 PREVENTION AND CHRONIC CARE MANAGEMENT

24 29 DIVISION XXII

24 30 PREVENTION AND CHRONIC CARE MANAGEMENT

24 31 Sec. 16. NEW SECTION. 135.158 DEFINITIONS.

24 32 For the purpose of this division, unless the context  
24 33 otherwise requires:

24 34 1. "Chronic care" means health care services provided by a  
24 35 health care professional for an established clinical condition  
25 1 that is expected to last a year or more and that requires  
25 2 ongoing clinical management attempting to restore the  
25 3 individual to highest function, minimize the negative effects  
25 4 of the chronic condition, and prevent complications related to  
25 5 the chronic condition.

25 6 2. "Chronic care information system" means approved  
25 7 information technology to enhance the development and  
25 8 communication of information to be used in providing chronic  
25 9 care, including clinical, social, and economic outcomes of  
25 10 chronic care.

25 11 3. "Chronic care management" means a system of coordinated  
25 12 health care interventions and communications for individuals  
25 13 with chronic conditions, including significant patient  
25 14 self-care efforts, systemic supports for the health care  
25 15 professional and patient relationship, and a chronic care plan

25 16 emphasizing prevention of complications utilizing  
25 17 evidence-based practice guidelines, patient empowerment  
25 18 strategies, and evaluation of clinical, humanistic, and  
25 19 economic outcomes on an ongoing basis with the goal of  
25 20 improving overall health.

25 21 4. "Chronic care plan" means a plan of care between an  
25 22 individual and the individual's principal health care  
25 23 professional that emphasizes prevention of complications  
25 24 through patient empowerment including but not limited to  
25 25 providing incentives to engage the patient in the patient's  
25 26 own care and in clinical, social, or other interventions  
25 27 designed to minimize the negative effects of the chronic  
25 28 condition.

25 29 5. "Chronic care resources" means health care  
25 30 professionals, advocacy groups, health departments, schools of  
25 31 public health and medicine, health plans, and others with  
25 32 expertise in public health, health care delivery, health care  
25 33 financing, and health care research.

25 34 6. "Chronic condition" means an established clinical  
25 35 condition that is expected to last a year or more and that  
26 1 requires ongoing clinical management.

26 2 7. "Department" means the department of public health.

26 3 8. "Director" means the director of public health.

26 4 9. "Eligible individual" means a resident of this state  
26 5 who has been diagnosed with a chronic condition or is at an  
26 6 elevated risk for a chronic condition and who is a recipient  
26 7 of medical assistance, is a member of the expansion population  
26 8 pursuant to chapter 249J, is an inmate of a correctional  
26 9 institution in this state, or is an individual who has  
26 10 qualified health care coverage through the Iowa choice health  
26 11 care coverage program created in section 514E.5.

26 12 10. "Health care professional" means health care  
26 13 professional as defined in section 135.154.

26 14 11. "Health risk assessment" means screening by a health  
26 15 care professional for the purpose of assessing an individual's  
26 16 health, including tests or physical examinations and a survey  
26 17 or other tool used to gather information about an individual's  
26 18 health, medical history, and health risk factors during a  
26 19 health screening.

26 20 12. "State initiative for prevention and chronic care  
26 21 management" or "state initiative" means the state's plan for  
26 22 developing a chronic care organizational structure for  
26 23 prevention and chronic care management, including coordinating  
26 24 the efforts of health care professionals and chronic care  
26 25 resources to promote the health of residents and the  
26 26 prevention and management of chronic conditions, developing  
26 27 and implementing arrangements for delivering prevention  
26 28 services and chronic care management, developing significant  
26 29 patient self-care efforts, providing systemic support for the  
26 30 health care professional-patient relationship and options for  
26 31 channeling chronic care resources and support to health care  
26 32 professionals, providing for community development and  
26 33 outreach and education efforts, and coordinating information  
26 34 technology initiatives with the chronic care information  
26 35 system.

27 1 Sec. 17. NEW SECTION. 135.159 PREVENTION AND CHRONIC  
27 2 CARE MANAGEMENT INITIATIVE == ADVISORY COUNCIL.

27 3 1. The director, in collaboration with the prevention and  
27 4 chronic care management advisory council, shall develop a  
27 5 state initiative for prevention and chronic care management.

27 6 2. The director may accept grants and donations and shall  
27 7 apply for any federal, state, or private grants available to  
27 8 fund the initiative. Any grants or donations received shall  
27 9 be placed in a separate fund in the state treasury and used  
27 10 exclusively for the initiative or as directed by the source of  
27 11 the grant or donation.

27 12 3. The director shall establish and convene an advisory  
27 13 council to provide technical assistance to the director in  
27 14 developing a state initiative that integrates evidence-based  
27 15 prevention and chronic care management strategies into the  
27 16 public and private health care systems, including the medical  
27 17 home system. The advisory council, at a minimum, shall  
27 18 include all of the following members:

27 19 a. The director of human services, or the director's  
27 20 designee.

27 21 b. The director of the department of elder affairs, or the  
27 22 director's designee.

27 23 c. The commissioner of insurance, or the commissioner's  
27 24 designee.

27 25 d. A representative of the Iowa medical society.

27 26 e. A representative of the Iowa hospital association.

27 27 f. A representative of health insurers.  
27 28 g. A medical social worker or home care professional.  
27 29 h. A patient advocate.  
27 30 i. A primary care physician.  
27 31 j. A representative of the Iowa pharmacy association.  
27 32 k. A specialist in public health and epidemiology.  
27 33 l. An expert in health outcomes research.  
27 34 m. A representative of an entity that is taking a leading  
27 35 role in health information technology.  
28 1 n. A representative of the Iowa college of public health  
28 2 at the university of Iowa.  
28 3 o. A representative of Des Moines university ==  
28 4 osteopathic medical center.  
28 5 p. A representative of the Iowa chiropractic society.  
28 6 4. a. Members of the advisory council from the  
28 7 organizations specified in subsection 3 shall be selected by  
28 8 the respective organization. Terms of the public members  
28 9 shall begin and end as provided by section 69.19. Any vacancy  
28 10 shall be filled in the same manner as regular appointments are  
28 11 made for the unexpired portion of the regular term. Public  
28 12 members shall serve terms of three years. A public member is  
28 13 eligible for reappointment for two successive terms.  
28 14 b. Public members shall receive their actual and necessary  
28 15 expenses incurred in the performance of their duties and may  
28 16 be eligible to receive compensation as provided in section  
28 17 7E.6.  
28 18 c. The advisory council shall meet at least quarterly and  
28 19 in accordance with the rules adopted by the advisory council.  
28 20 d. A majority of the voting members of the advisory  
28 21 council constitutes a quorum. Any action taken by the  
28 22 advisory council must be adopted by the affirmative vote of a  
28 23 majority of its membership.  
28 24 e. The advisory council is located for administrative  
28 25 purposes within the division of health promotion and chronic  
28 26 disease management within the department. The department  
28 27 shall provide administrative support to the advisory council.  
28 28 5. The advisory council shall elicit input from a variety  
28 29 of health care professionals, health care professional  
28 30 organizations, community and nonprofit groups, insurers,  
28 31 consumers, businesses, school districts, and state and local  
28 32 governments in developing the advisory council's  
28 33 recommendations.  
28 34 6. The advisory council shall submit initial  
28 35 recommendations to the director for the state initiative for  
29 1 prevention and chronic care management no later than July 1,  
29 2 2009. The recommendations shall address all of the following:  
29 3 a. The recommended organizational structure for  
29 4 integrating prevention and chronic care management into the  
29 5 private and public health care systems. The organizational  
29 6 structure recommended shall align with the organizational  
29 7 structure established for the medical home system developed  
29 8 pursuant to division XXI. The advisory council shall also  
29 9 review existing prevention and chronic care management  
29 10 strategies used in the health insurance market and in private  
29 11 and public programs and recommend ways to expand the use of  
29 12 such strategies throughout the health insurance market and in  
29 13 the private and public health care systems.  
29 14 b. A process for identifying leading health care  
29 15 professionals and existing prevention and chronic care  
29 16 management programs in the state, and coordinating care among  
29 17 these health care professionals and programs.  
29 18 c. A prioritization of the chronic conditions for which  
29 19 prevention and chronic care management services should be  
29 20 provided, taking into consideration the prevalence of specific  
29 21 chronic conditions and the factors that may lead to the  
29 22 development of chronic conditions; the fiscal impact to state  
29 23 health care programs of providing care for the chronic  
29 24 conditions of eligible individuals; the availability of  
29 25 workable, evidence-based approaches to chronic care for the  
29 26 chronic condition; and public input into the selection  
29 27 process. The advisory council shall initially develop  
29 28 consensus guidelines to address the two chronic conditions  
29 29 identified as having the highest priority and shall also  
29 30 specify a timeline for inclusion of additional specific  
29 31 chronic conditions in the initiative.  
29 32 d. A method to involve health care professionals in  
29 33 identifying eligible patients for prevention and chronic care  
29 34 management services, which includes but is not limited to the  
29 35 use of a health risk assessment.  
30 1 e. The methods for increasing communication between health  
30 2 care professionals and patients, including patient education,

30 3 patient self-management, and patient follow-up plans.  
30 4 f. The educational, wellness, and clinical management  
30 5 protocols and tools to be used by health care professionals,  
30 6 including management guideline materials for health care  
30 7 delivery.  
30 8 g. The use and development of process and outcome measures  
30 9 and benchmarks, aligned to the greatest extent possible with  
30 10 existing measures and benchmarks such as the best in class  
30 11 estimates utilized in the national healthcare quality report  
30 12 of the agency for health care research and quality of the  
30 13 United States department of health and human services, to  
30 14 provide performance feedback for health care professionals and  
30 15 information on the quality of health care, including patient  
30 16 satisfaction and health status outcomes.  
30 17 h. Payment methodologies to align reimbursements and  
30 18 create financial incentives and rewards for health care  
30 19 professionals to utilize prevention services, establish  
30 20 management systems for chronic conditions, improve health  
30 21 outcomes, and improve the quality of health care, including  
30 22 case management fees, payment for technical support and data  
30 23 entry associated with patient registries, and the cost of  
30 24 staff coordination within a medical practice.  
30 25 i. Methods to involve public and private groups, health  
30 26 care professionals, insurers, third-party administrators,  
30 27 associations, community and consumer groups, and other  
30 28 entities to facilitate and sustain the initiative.  
30 29 j. Alignment of any chronic care information system or  
30 30 other information technology needs with other health care  
30 31 information technology initiatives.  
30 32 k. Involvement of appropriate health resources and public  
30 33 health and outcomes researchers to develop and implement a  
30 34 sound basis for collecting data and evaluating the clinical,  
30 35 social, and economic impact of the initiative, including a  
31 1 determination of the impact on expenditures and prevalence and  
31 2 control of chronic conditions.  
31 3 l. Elements of a marketing campaign that provides for  
31 4 public outreach and consumer education in promoting prevention  
31 5 and chronic care management strategies among health care  
31 6 professionals, health insurers, and the public.  
31 7 m. A method to periodically determine the percentage of  
31 8 health care professionals who are participating, the success  
31 9 of the empowerment-of-patients approach, and any results of  
31 10 health outcomes of the patients participating.  
31 11 n. A means of collaborating with the health professional  
31 12 licensing boards under chapter 147 to review prevention and  
31 13 chronic care management education provided to licensees, as  
31 14 appropriate, and recommendations regarding education resources  
31 15 and curricula for integration into existing and new education  
31 16 and training programs.  
31 17 o. The establishment of a health and wellness strategies  
31 18 consortium to act as a catalyst in advancing voluntarily  
31 19 adopted strategies to improve quality of care, increase access  
31 20 to services, reduce disparities in health care delivery and  
31 21 contain costs while emphasizing population health and  
31 22 wellness. The core membership of the consortium shall include  
31 23 representatives of health care purchasers, payers, and  
31 24 providers. The consortium shall direct strategies for health  
31 25 care payers and providers to adopt which may include but are  
31 26 not limited to strategies to promote wellness which may  
31 27 include:  
31 28 (1) Providing smoking cessation programs as a standard  
31 29 health care benefit including reimbursement for treatment and  
31 30 support services.  
31 31 (2) Providing obesity prevention services as a standard  
31 32 health care benefit.  
31 33 (3) Increasing immunization rates for pneumococcus and  
31 34 influenza which may include approving an administration fee  
31 35 for all qualified providers of influenza and pneumococcal  
32 1 vaccinations.  
32 2 (4) Providing health care benefit incentives for consumers  
32 3 who participate in wellness programs.  
32 4 (5) Assuring that health care coverage for children  
32 5 includes primary, preventive, and developmental health  
32 6 services.  
32 7 7. Following submission of the initial recommendations to  
32 8 the director by July 1, 2009, and initial implementation among  
32 9 the population of eligible individuals, the director shall  
32 10 work with the department of human services, insurers, health  
32 11 care professional organizations, and consumers in implementing  
32 12 the initiative beyond the population of eligible individuals  
32 13 as an integral part of the health care delivery system in this

32 14 state. The advisory council shall continue to review and make  
32 15 recommendations to the director regarding improvements in the  
32 16 initiative.

32 17 8. The director of human services shall obtain any federal  
32 18 waivers or state plan amendments necessary to implement the  
32 19 prevention and chronic care management initiative within the  
32 20 medical assistance, hawk=i, and IowaCare populations.

32 21 Sec. 18. NEW SECTION. 135.160 CLINICIANS ADVISORY PANEL.

32 22 1. The director shall convene a clinicians advisory panel  
32 23 to advise and recommend to the department clinically  
32 24 appropriate, evidence-based best practices regarding the  
32 25 implementation of the medical home as defined in section  
32 26 135.154 and the prevention and chronic care management  
32 27 initiative pursuant to section 135.159. The director shall  
32 28 act as chairperson of the advisory panel.

32 29 2. The clinicians advisory panel shall consist of nine  
32 30 members representing licensed medical health care providers  
32 31 selected by their respective professional organizations.  
32 32 Terms of members shall begin and end as provided in section  
32 33 69.19. Any vacancy shall be filled in the same manner as  
32 34 regular appointments are made for the unexpired portion of the  
32 35 regular term. Members shall serve terms of three years. A  
33 1 member is eligible for reappointment for three successive  
33 2 terms.

33 3 3. The clinicians advisory panel shall meet on a quarterly  
33 4 basis to receive updates from the director regarding strategic  
33 5 planning and implementation progress on the medical home and  
33 6 the prevention and chronic care management initiative and  
33 7 shall provide clinical consultation to the department  
33 8 regarding the medical home and the initiative.

33 9 Sec. 19. NEW SECTION. 8A.440 PREVENTION AND CHRONIC CARE  
33 10 MANAGEMENT == HEALTH BENEFIT PLAN.

33 11 The department shall include in any request for proposals  
33 12 for the administration of the health benefit plans for state  
33 13 employees a request for a description of any prevention and  
33 14 chronic care management program provided by the entity  
33 15 offering the health benefit plan. The department shall also  
33 16 work with the department of public health regarding how and  
33 17 when to align the state employees' health benefit plan with  
33 18 the provisions developed for the prevention and chronic care  
33 19 management initiative created in chapter 135, division XXII.

33 20 DIVISION VI  
33 21 IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

33 22 Sec. 20. NEW SECTION. 8.70 DEFINITIONS.

33 23 As used in this division, unless the context otherwise  
33 24 requires:

33 25 1. "Health care professional" means health care  
33 26 professional as defined in section 135.154.

33 27 2. "Health information technology" means the application  
33 28 of information processing, involving both computer hardware  
33 29 and software, that deals with the storage, retrieval, sharing,  
33 30 and use of health care information, data, and knowledge for  
33 31 communication, decision making, quality, safety, and  
33 32 efficiency of clinical practice, and may include but is not  
33 33 limited to:

33 34 a. An electronic health record that electronically  
33 35 compiles and maintains health information that may be derived  
34 1 from multiple sources about the health status of an individual  
34 2 and may include a core subset of each care delivery  
34 3 organization's electronic medical record such as a continuity  
34 4 of care record or a continuity of care document, computerized  
34 5 physician order entry, electronic prescribing, or clinical  
34 6 decision support.

34 7 b. A personal health record through which an individual  
34 8 and any other person authorized by the individual can maintain  
34 9 and manage the individual's health information.

34 10 c. An electronic medical record that is used by health  
34 11 care professionals to electronically document, monitor, and  
34 12 manage health care delivery within a care delivery  
34 13 organization, is the legal record of the patient's encounter  
34 14 with the care delivery organization, and is owned by the care  
34 15 delivery organization.

34 16 d. A computerized provider order entry function that  
34 17 permits the electronic ordering of diagnostic and treatment  
34 18 services, including prescription drugs.

34 19 e. A decision support function to assist physicians and  
34 20 other health care providers in making clinical decisions by  
34 21 providing electronic alerts and reminders to improve  
34 22 compliance with best practices, promote regular screenings and  
34 23 other preventive practices, and facilitate diagnoses and  
34 24 treatments.

34 25 f. Tools to allow for the collection, analysis, and  
34 26 reporting of information or data on adverse events, the  
34 27 quality and efficiency of care, patient satisfaction, and  
34 28 other health care-related performance measures.

34 29 3. "Interoperability" means the ability of two or more  
34 30 systems or components to exchange information or data in an  
34 31 accurate, effective, secure, and consistent manner and to use  
34 32 the information or data that has been exchanged and includes  
34 33 but is not limited to:

34 34 a. The capacity to connect to a network for the purpose of  
34 35 exchanging information or data with other users.

35 1 b. The ability of a connected, authenticated user to  
35 2 demonstrate appropriate permissions to participate in the  
35 3 instant transaction over the network.

35 4 c. The capacity of a connected, authenticated user to  
35 5 access, transmit, receive, and exchange usable information  
35 6 with other users.

35 7 4. "Recognized interoperability standard" means  
35 8 interoperability standards recognized by the office of the  
35 9 national coordinator for health information technology of the  
35 10 United States department of health and human services.

35 11 Sec. 21. NEW SECTION. 8.71 IOWA ELECTRONIC HEALTH ==  
35 12 PRINCIPLES == GOALS.

35 13 1. Health information technology is rapidly evolving so  
35 14 that it can contribute to the goal of improving access to and  
35 15 quality of health care, enhancing efficiency, and reducing  
35 16 costs.

35 17 2. To be effective, the health information technology  
35 18 system shall comply with all of the following principles:

35 19 a. Be patient-centered and market-driven.

35 20 b. Be based on approved standards developed with input  
35 21 from all stakeholders.

35 22 c. Protect the privacy of consumers and the security and  
35 23 confidentiality of all health information.

35 24 d. Promote interoperability.

35 25 e. Ensure the accuracy, completeness, and uniformity of  
35 26 data.

35 27 3. Widespread adoption of health information technology is  
35 28 critical to a successful health information technology system  
35 29 and is best achieved when all of the following occur:

35 30 a. The market provides a variety of certified products  
35 31 from which to choose in order to best fit the needs of the  
35 32 user.

35 33 b. The system provides incentives for health care  
35 34 professionals to utilize the health information technology and  
35 35 provides rewards for any improvement in quality and efficiency  
36 1 resulting from such utilization.

36 2 c. The system provides protocols to address critical  
36 3 problems.

36 4 d. The system is financed by all who benefit from the  
36 5 improved quality, efficiency, savings, and other benefits that  
36 6 result from use of health information technology.

36 7 Sec. 22. NEW SECTION. 8.72 IOWA ELECTRONIC HEALTH  
36 8 INFORMATION COMMISSION.

36 9 1. a. An electronic health information commission is  
36 10 created as a public and private collaborative effort to  
36 11 promote the adoption and use of health information technology  
36 12 in this state in order to improve health care quality,  
36 13 increase patient safety, reduce health care costs, enhance  
36 14 public health, and empower individuals and health care  
36 15 professionals with comprehensive, real-time medical  
36 16 information to provide continuity of care and make the best  
36 17 health care decisions. The commission shall provide oversight  
36 18 for the development, implementation, and coordination of an  
36 19 interoperable electronic health records system, telehealth  
36 20 expansion efforts, the health information technology  
36 21 infrastructure, and other health information technology  
36 22 initiatives in this state.

36 23 b. All health information technology efforts shall  
36 24 endeavor to represent the interests and meet the needs of  
36 25 consumers and the health care sector, protect the privacy of  
36 26 individuals and the confidentiality of individuals'  
36 27 information, promote physician best practices, and make  
36 28 information easily accessible to the appropriate parties. The  
36 29 system developed shall be consumer-driven, flexible, and  
36 30 expandable.

36 31 2. The commission shall consist of the following voting  
36 32 members:

36 33 a. Individuals with broad experience and vision in health  
36 34 care and health technology and one member representing the  
36 35 health care consumer. The voting members shall be appointed

37 1 by the governor, subject to confirmation by the senate. The  
37 2 voting members shall include all of the following:

- 37 3 (1) The director of the Iowa communications network.
- 37 4 (2) Two members who are the chief information officers of  
37 5 the two largest private health care systems.
- 37 6 (3) One member who is the chief information officer of a  
37 7 public health care system.
- 37 8 (4) A representative of the private telecommunications  
37 9 industry.
- 37 10 (5) A representative of a rural hospital that is a member  
37 11 of the Iowa hospital association.
- 37 12 (6) A consumer advocate.
- 37 13 (7) A representative of the Iowa safety net provider  
37 14 network created in section 135.153.

37 15 3. a. The members shall select a chairperson, annually,  
37 16 from among the membership, and shall serve terms of three  
37 17 years beginning and ending as provided in section 69.19.  
37 18 Voting member appointments shall comply with sections 69.16  
37 19 and 69.16A. Vacancies shall be filled by the original  
37 20 appointing authority and in the manner of the original  
37 21 appointments. Members shall receive reimbursement for actual  
37 22 expenses incurred while serving in their official capacity and  
37 23 voting members may also be eligible to receive compensation as  
37 24 provided in section 7E.6. A person appointed to fill a  
37 25 vacancy for a member shall serve only for the unexpired  
37 26 portion of the term. A member is eligible for reappointment  
37 27 for two successive terms.

37 28 b. The commission shall meet at least quarterly and at the  
37 29 call of the chairperson. A majority of the voting members of  
37 30 the commission constitutes a quorum. Any action taken by the  
37 31 commission must be adopted by the affirmative vote of a  
37 32 majority of its voting membership.

37 33 c. The commission is located for administrative purposes  
37 34 within the department of management. The department shall  
37 35 provide office space, staff assistance, administrative  
38 1 support, and necessary supplies and equipment for the  
38 2 commission.

38 3 4. The commission shall do all of the following:

38 4 a. Establish an advisory council which shall consist of  
38 5 the representatives of entities involved in the electronic  
38 6 health records system task force established pursuant to  
38 7 section 217.41A, Code 2007, and any other members the  
38 8 commission determines necessary to assist in the commission's  
38 9 duties including but not limited to consumers and consumer  
38 10 advocacy organizations; physicians and health care  
38 11 professionals; pharmacists; leadership of community hospitals  
38 12 and major integrated health care delivery networks; state  
38 13 agencies including the department of public health, the  
38 14 department of human services, the department of elder affairs,  
38 15 the division of insurance of the department of commerce, and  
38 16 the office of the attorney general; health plans and health  
38 17 insurers; legal experts; academics and ethicists; business  
38 18 leaders; and professional associations.

38 19 b. Adopt a statewide health information technology plan by  
38 20 January 1, 2009. In developing the plan, the commission shall  
38 21 seek the input of providers, payers, and consumers. Standards  
38 22 and policies developed for the plan shall promote and be  
38 23 consistent with national standards developed by the office of  
38 24 the national coordinator for health information technology of  
38 25 the United States department of health and human services and  
38 26 shall address or provide for all of the following:

38 27 (1) The effective, efficient, statewide use of electronic  
38 28 health information in patient care, health care policymaking,  
38 29 clinical research, health care financing, and continuous  
38 30 quality improvement. The commission shall adopt requirements  
38 31 for interoperable electronic health records in this state  
38 32 including a recognized interoperability standard.

38 33 (2) Education of the public and health care sector about  
38 34 the value of health information technology in improving  
38 35 patient care, and methods to promote increased support and  
39 1 collaboration of state and local public health agencies,  
39 2 health care professionals, and consumers in health information  
39 3 technology initiatives.

39 4 (3) Standards for the exchange of health care information.

39 5 (4) Policies relating to the protection of privacy of  
39 6 patients and the security and confidentiality of patient  
39 7 information.

39 8 (5) Policies relating to information ownership.

39 9 (6) Policies relating to governance of the various facets  
39 10 of the health information technology system.

39 11 (7) A single patient identifier or alternative mechanism

39 12 to share secure patient information. If no alternative  
39 13 mechanism is acceptable to the commission, all health care  
39 14 professionals shall utilize the mechanism selected by the  
39 15 commission by January 1, 2010.

39 16 (8) A standard continuity of care record and other issues  
39 17 related to the content of electronic transmissions. All  
39 18 health care professionals shall utilize the standard  
39 19 continuity of care record by January 1, 2010.

39 20 (9) Requirements for electronic prescribing.

39 21 (10) Economic incentives and support to facilitate  
39 22 participation in an interoperable system by health care  
39 23 professionals.

39 24 c. Identify existing and potential health information  
39 25 technology efforts in this state, regionally, and nationally,  
39 26 and integrate existing efforts to avoid incompatibility  
39 27 between efforts and avoid duplication.

39 28 d. Coordinate public and private efforts to provide the  
39 29 network backbone infrastructure for the health information  
39 30 technology system. In coordinating these efforts, the  
39 31 commission shall do all of the following:

39 32 (1) Adopt policies to effectuate the logical cost  
39 33 effective usage of and access to the state-owned network, and  
39 34 support of telecommunication carrier products, where  
39 35 applicable.

40 1 (2) Complete a memorandum of understanding with the Iowa  
40 2 communications network for governmental access usage, with  
40 3 private fiber optic networks for core backbone usage of  
40 4 private fiber optic networks, and with any other  
40 5 communications entity for state-subsidized usage of the  
40 6 communications entity's products to access any backbone  
40 7 network.

40 8 (3) Establish protocols to ensure compliance with any  
40 9 applicable federal standards.

40 10 (4) Determine costs for accessing the network at a level  
40 11 that provides sufficient funding for the network.

40 12 e. Promote the use of telemedicine.

40 13 (1) Examine existing barriers to the use of telemedicine  
40 14 and make recommendations for eliminating these barriers.

40 15 (2) Examine the most efficient and effective systems of  
40 16 technology for use and make recommendations based on the  
40 17 findings.

40 18 f. Address the workforce needs generated by increased use  
40 19 of health information technology.

40 20 g. Adopt rules in accordance with chapter 17A to implement  
40 21 all aspects of the statewide plan and the network.

40 22 h. Coordinate, monitor, and evaluate the adoption, use,  
40 23 interoperability, and efficiencies of the various facets of  
40 24 health information technology in this state.

40 25 i. Seek and apply for any federal or private funding to  
40 26 assist in the implementation and support of the health  
40 27 information technology system and make recommendations for  
40 28 funding mechanisms for the ongoing development and maintenance  
40 29 costs of the health information technology system.

40 30 j. Identify state laws and rules that present barriers to  
40 31 the development of the health information technology system  
40 32 and recommend any changes to the governor and the general  
40 33 assembly.

40 34 Sec. 23. Section 8D.13, Code 2007, is amended by adding  
40 35 the following new subsection:

41 1 NEW SUBSECTION. 20. Access shall be offered to the Iowa  
41 2 hospital association for the collection, maintenance, and  
41 3 dissemination of health and financial data for hospitals and  
41 4 for hospital educational services. The Iowa hospital  
41 5 association shall be responsible for all costs associated with  
41 6 becoming part of the network, as determined by the commission.

41 7 Sec. 24. Section 217.41A, Code 2007, is repealed.

41 8 DIVISION VII

41 9 LONG-TERM CARE PLANNING AND  
41 10 PATIENT AUTONOMY IN HEALTH CARE

41 11 Sec. 25. NEW SECTION. 231.62 END-OF-LIFE DECISION  
41 12 MAKING.

41 13 1. The department shall consult with the Iowa medical  
41 14 society, the Iowa end-of-life coalition, the Iowa hospice  
41 15 organization, the university of Iowa palliative care program,  
41 16 and other health care professionals whose scope of practice  
41 17 includes end-of-life care, to develop educational and  
41 18 patient-centered information on end-of-life care for  
41 19 terminally ill patients and health care professionals.

41 20 2. For the purposes of this section, "end-of-life care"  
41 21 means care provided to address the physical, psychological,  
41 22 social, spiritual, and practical needs of terminally ill

41 23 patients and their caregivers.  
41 24 Sec. 26. LONG-TERM LIVING PLANNING TOOLS == PUBLIC  
41 25 EDUCATION CAMPAIGN. The legal services development and  
41 26 substitute decision maker programs of the department of elder  
41 27 affairs, in collaboration with other appropriate agencies and  
41 28 interested parties, shall research existing long-term living  
41 29 planning tools that are designed to increase quality of life  
41 30 and contain health care costs and recommend a public education  
41 31 campaign strategy on long-term living to the general assembly  
41 32 by January 1, 2009.

41 33 Sec. 27. LONG-TERM CARE OPTIONS PUBLIC EDUCATION CAMPAIGN.  
41 34 The department of elder affairs, in collaboration with the  
41 35 insurance division of the department of commerce, shall  
42 1 implement a long-term care options public education campaign.  
42 2 The campaign may utilize such tools as the "Own Your Future  
42 3 Planning Kit" administered by the centers for Medicare and  
42 4 Medicaid services, the administration on aging, and the office  
42 5 of the assistant secretary for planning and evaluation of the  
42 6 United States department of health and human services, and  
42 7 other tools developed through the aging and disability  
42 8 resource center program of the administration on aging and the  
42 9 centers for Medicare and Medicaid services designed to promote  
42 10 health and independence as Iowans age, assist older Iowans in  
42 11 making informed choices about the availability of long-term  
42 12 care options, including alternatives to facility-based care,  
42 13 and to streamline access to long-term care.

42 14 Sec. 28. HOME AND COMMUNITY-BASED SERVICES PUBLIC  
42 15 EDUCATION CAMPAIGN. The department of elder affairs shall  
42 16 work with other public and private agencies to identify  
42 17 resources that may be used to continue the work of the aging  
42 18 and disability resource center established by the department  
42 19 through the aging and disability resource center grant program  
42 20 efforts of the administration on aging and the centers for  
42 21 Medicare and Medicaid services of the United States department  
42 22 of health and human services, beyond the federal grant period  
42 23 ending September 30, 2008.

42 24 Sec. 29. PATIENT AUTONOMY IN HEALTH CARE DECISIONS PILOT  
42 25 PROJECT.

42 26 1. The department of public health shall establish a  
42 27 two-year community coalition for patient treatment wishes  
42 28 across the health care continuum pilot project, beginning July  
42 29 1, 2008, and ending June 30, 2010, in a county with a  
42 30 population of between fifty thousand and one hundred thousand.  
42 31 The pilot project shall utilize the process based upon the  
42 32 national physicians orders for life sustaining treatment  
42 33 program initiative, including use of a standardized physician  
42 34 order for scope of treatment form. The pilot project may  
42 35 include applicability to chronically ill, frail, and elderly  
43 1 or terminally ill individuals in hospitals licensed pursuant  
43 2 to chapter 135B, nursing facilities or residential care  
43 3 facilities licensed pursuant to chapter 135C, or hospice  
43 4 programs licensed pursuant to chapter 135J.

43 5 2. The department of public health shall convene an  
43 6 advisory council, consisting of representatives of entities  
43 7 with interest in the pilot project, including but not limited  
43 8 to the Iowa hospital association, the Iowa medical society,  
43 9 organizations representing health care facilities,  
43 10 representatives of health care providers, and the Iowa trial  
43 11 lawyers association, to develop recommendations for expanding  
43 12 the pilot project statewide. The advisory council shall hold  
43 13 meetings throughout the state to obtain input regarding the  
43 14 pilot project and its statewide application. Based on  
43 15 information collected regarding the pilot project and  
43 16 information obtained through its meetings, the advisory  
43 17 council shall report its findings and recommendations,  
43 18 including recommendations for legislation, to the governor and  
43 19 the general assembly by January 1, 2010.

43 20 3. The pilot project shall not alter the rights of  
43 21 individuals who do not execute a physician order for scope of  
43 22 treatment.

43 23 a. If an individual is a qualified patient as defined in  
43 24 section 144A.2, the individual's declaration executed under  
43 25 chapter 144A shall control health care decision making for the  
43 26 individual in accordance with chapter 144A. A physician order  
43 27 for scope of treatment shall not supersede a declaration  
43 28 executed pursuant to chapter 144A. If an individual has not  
43 29 executed a declaration pursuant to chapter 144A, health care  
43 30 decision making relating to life-sustaining procedures for the  
43 31 individual shall be governed by section 144A.7.

43 32 b. If an individual has executed a durable power of  
43 33 attorney for health care pursuant to chapter 144B, the

43 34 individual's durable power of attorney for health care shall  
43 35 control health care decision making for the individual in  
44 1 accordance with chapter 144B. A physician order for scope of  
44 2 treatment shall not supersede a durable power of attorney for  
44 3 health care executed pursuant to chapter 144B.  
44 4 c. In the absence of actual notice of the revocation of a  
44 5 physician order for scope of treatment, a physician, health  
44 6 care provider, or any other person who complies with a  
44 7 physician order for scope of treatment shall not be subject to  
44 8 liability, civil or criminal, for actions taken under this  
44 9 section which are in accordance with reasonable medical  
44 10 standards. Any physician, health care provider, or other  
44 11 person against whom criminal or civil liability is asserted  
44 12 because of conduct in compliance with this section may  
44 13 interpose the restriction on liability in this paragraph as an  
44 14 absolute defense.

44 15 DIVISION VIII

44 16 OFFICE OF HEALTH CARE QUALITY, COST CONTAINMENT,  
44 17 AND CONSUMER INFORMATION

44 18 Sec. 30. NEW SECTION. 135.29A OFFICE OF HEALTH CARE  
44 19 QUALITY, COST CONTAINMENT, AND CONSUMER INFORMATION.

44 20 1. An office of health care quality, cost containment, and  
44 21 consumer information is created in the department.

44 22 2. The office shall, at a minimum, do all of the  
44 23 following:

44 24 a. Develop and implement cost=containment measures that  
44 25 help to contain costs while improving quality in the health  
44 26 care system.

44 27 b. Provide for coordination of public and private  
44 28 cost=containment, quality, and safety efforts in this state,  
44 29 including but not limited to efforts of the Iowa healthcare  
44 30 collaborative and the Iowa health buyers' alliance.

44 31 c. Carry out other health care price, quality, and  
44 32 safety-related research as directed by the governor and the  
44 33 general assembly.

44 34 d. Develop strategies to contain health care costs which  
44 35 may include:

45 1 (1) Promoting adoption of health information technology  
45 2 through provider incentives.

45 3 (2) Considering a four-tier prescription drug copayment  
45 4 system within a prescription drug benefit that includes a zero  
45 5 copayment tier for select medications to improve patient  
45 6 compliance.

45 7 (3) Providing a standard medication therapy management  
45 8 program as a prescription drug benefit to optimize high=risk  
45 9 patients' medication outcomes.

45 10 (4) Investigating whether pooled purchasing for  
45 11 prescription drug benefits, such as a common statewide  
45 12 preferred drug list, would decrease costs.

45 13 e. Develop strategies to increase the public's role and  
45 14 responsibility in personal health care choices and decisions  
45 15 which may include:

45 16 (1) Creating a public awareness campaign to educate  
45 17 consumers on smart health care choices.

45 18 (2) Promoting public reporting of quality performance  
45 19 measures.

45 20 f. Develop implementation strategies which may include  
45 21 piloting the various quality, cost=containment, and public  
45 22 involvement strategies utilizing publicly funded health care  
45 23 coverage groups such as the medical assistance program, state  
45 24 of Iowa employee group health plans, and regents institutions  
45 25 health care plans, consistent with collective bargaining  
45 26 agreements in effect.

45 27 g. Develop a method for health care providers to provide a  
45 28 patient, upon request, with a reasonable estimate of charges  
45 29 for the services.

45 30 h. Identify the process and time frames for implementation  
45 31 of any initiatives, identify any barriers to implementation of  
45 32 initiatives, and recommend any changes in law or rules  
45 33 necessary to eliminate the barriers and to implement the  
45 34 initiatives.

45 35 DIVISION V

46 1 BUREAU OF HEALTH CARE ACCESS

46 2 Sec. 31. NEW SECTION. 135.45 BUREAU OF HEALTH CARE  
46 3 ACCESS.

46 4 A bureau of health care access is created to coordinate  
46 5 public and private efforts to develop and maintain an  
46 6 appropriate health care delivery infrastructure and a stable,  
46 7 well-qualified, diverse, and sustainable health care workforce  
46 8 in this state. The bureau shall, at a minimum, do all of the  
46 9 following:

46 10 1. Develop a strategic plan for health care delivery  
46 11 infrastructure and health care workforce resources in this  
46 12 state.  
46 13 2. Provide for the continuous collection of data to  
46 14 provide a basis for health care strategic planning and health  
46 15 care policymaking.  
46 16 3. Make recommendations regarding the health care delivery  
46 17 infrastructure and the workforce that assist in monitoring  
46 18 current needs, predicting future trends, and informing  
46 19 policymaking.  
46 20 4. Administer the certificate of need program and provide  
46 21 support to the health facilities council established in  
46 22 section 135.62.

46 23 Sec. 32. NEW SECTION. 135.46 STRATEGIC PLAN.

46 24 1. The strategic plan for health care delivery  
46 25 infrastructure and health care workforce resources shall  
46 26 describe the existing health care system, describe and provide  
46 27 a rationale for the desired health care system, provide an  
46 28 action plan for implementation, and provide methods to  
46 29 evaluate the system. The plan shall incorporate expenditure  
46 30 control methods and integrate criteria for evidence-based  
46 31 health care. The bureau of health care access shall do all of  
46 32 the following in developing the strategic plan for health care  
46 33 delivery infrastructure and health care workforce resources:

46 34 a. Conduct strategic health planning activities related to  
46 35 preparation of the strategic plan.

47 1 b. Develop a computerized system for accessing, analyzing,  
47 2 and disseminating data relevant to strategic health planning.  
47 3 The bureau may enter into data sharing agreements and  
47 4 contractual arrangements necessary to obtain or disseminate  
47 5 relevant data.

47 6 c. Conduct research and analysis or arrange for research  
47 7 and analysis projects to be conducted by public or private  
47 8 organizations to further the development of the strategic  
47 9 plan.

47 10 d. Establish a technical advisory committee to assist in  
47 11 the development of the strategic plan. The members of the  
47 12 committee may include but are not limited to health  
47 13 economists, health planners, representatives of health care  
47 14 purchasers, representatives of state and local agencies that  
47 15 regulate entities involved in health care, representatives of  
47 16 health care providers and health care facilities, and  
47 17 consumers.

47 18 2. The strategic plan shall include statewide health  
47 19 planning policies and goals related to the availability of  
47 20 health care facilities and services, the quality of care, and  
47 21 the cost of care. The policies and goals shall be based on  
47 22 the following principles:

47 23 a. That a strategic health planning process, responsive to  
47 24 changing health and social needs and conditions, is essential  
47 25 to the health, safety, and welfare of Iowans. The process  
47 26 shall be reviewed and updated as necessary to ensure that the  
47 27 strategic plan addresses all of the following:

47 28 (1) Promoting and maintaining the health of all Iowans.

47 29 (2) Providing accessible health care services through the  
47 30 maintenance of an adequate supply of health facilities and an  
47 31 adequate workforce.

47 32 (3) Controlling excessive increases in costs.

47 33 (4) Applying specific quality criteria and population  
47 34 health indicators.

47 35 (5) Recognizing prevention and wellness as priorities in  
48 1 health care programs to improve quality and reduce costs.

48 2 (6) Addressing periodic priority issues including disaster  
48 3 planning, public health threats, and public safety dilemmas.

48 4 (7) Coordinating health care delivery and resource  
48 5 development efforts among state agencies including those  
48 6 tasked with facility, services, and professional provider  
48 7 licensure; state and federal reimbursement; health service  
48 8 utilization data systems; and others.

48 9 b. That both consumers and providers throughout the state  
48 10 must be involved in the health planning process, outcomes of  
48 11 which shall be clearly articulated and available for public  
48 12 review and use.

48 13 c. That the supply of a health care service has a  
48 14 substantial impact on utilization of the service, independent  
48 15 of the effectiveness, medical necessity, or appropriateness of  
48 16 the particular health care service for a particular  
48 17 individual.

48 18 d. That given that health care resources are not  
48 19 unlimited, the impact of any new health care service or  
48 20 facility on overall health expenditures in this state must be

48 21 considered.

48 22 e. That excess capacity of health care services and  
48 23 facilities places an increased economic burden on the public.

48 24 f. That the likelihood that a requested new health care  
48 25 facility, service, or equipment will improve health care  
48 26 quality and outcomes must be considered.

48 27 g. That development and ongoing maintenance of current and  
48 28 accurate health care information and statistics related to  
48 29 cost and quality of health care and projections of the need  
48 30 for health care facilities and services are necessary to  
48 31 developing an effective health care planning strategy.

48 32 h. That the certificate of need program as a component of  
48 33 the health care planning regulatory process must balance  
48 34 considerations of access to quality care at a reasonable cost  
48 35 for all Iowans, optimal use of existing health care resources,  
49 1 fostering of expenditure control, and elimination of  
49 2 unnecessary duplication of health care facilities and  
49 3 services, while supporting improved health care outcomes.

49 4 i. That strategic health care planning must be concerned  
49 5 with the stability of the health care system, encompassing  
49 6 health care financing, quality, and the availability of  
49 7 information and services for all residents.

49 8 3. The health care delivery infrastructure and resources  
49 9 strategic plan developed by the bureau shall include all of  
49 10 the following:

49 11 a. A health care system assessment and objectives  
49 12 component that does all of the following:

49 13 (1) Describes state and regional population demographics,  
49 14 health status indicators, and trends in health status and  
49 15 health care needs.

49 16 (2) Identifies key policy objectives for the state health  
49 17 care system related to access to care, health care outcomes,  
49 18 quality, and cost-effectiveness.

49 19 b. A health care facilities and services plan that  
49 20 assesses the demand for health care facilities and services to  
49 21 inform state health care planning efforts and direct  
49 22 certificate of need determinations, for those facilities and  
49 23 services subject to certificate of need. The plan shall  
49 24 include all of the following:

49 25 (1) An inventory of each geographic region's existing  
49 26 health care facilities and services.

49 27 (2) Projections of the need for each category of health  
49 28 care facility and service, including those subject to  
49 29 certificate of need.

49 30 (3) Policies to guide the addition of new or expanded  
49 31 health care facilities and services to promote the use of  
49 32 quality, evidence-based, cost-effective health care delivery  
49 33 options, including any recommendations for criteria,  
49 34 standards, and methods relevant to the certificate of need  
49 35 review process.

50 1 (4) An assessment of the availability of health care  
50 2 providers, public health resources, transportation  
50 3 infrastructure, and other considerations necessary to support  
50 4 the needed health care facilities and services in each region.

50 5 c. (1) A health care data resources plan that identifies  
50 6 data elements necessary to properly conduct planning  
50 7 activities and to review certificate of need applications,  
50 8 including data related to inpatient and outpatient utilization  
50 9 and outcomes information, and financial and utilization  
50 10 information related to charity care, quality, and cost.

50 11 (2) The plan shall inventory existing data resources, both  
50 12 public and private, that store and disclose information  
50 13 relevant to the health care planning process, including  
50 14 information necessary to conduct certificate of need  
50 15 activities. The plan shall identify any deficiencies in the  
50 16 inventory of existing data resources and the data necessary to  
50 17 conduct comprehensive health care planning activities. The  
50 18 plan may recommend that the bureau be authorized to access  
50 19 existing data sources and conduct appropriate analyses of such  
50 20 data or that other agencies expand their data collection  
50 21 activities as statutory authority permits. The plan may  
50 22 identify any computing infrastructure deficiencies that impede  
50 23 the proper storage, transmission, and analysis of health care  
50 24 planning data.

50 25 (3) The plan shall provide recommendations for increasing  
50 26 the availability of data related to health care planning to  
50 27 provide greater community involvement in the health care  
50 28 planning process and consistency in data used for certificate  
50 29 of need applications and determinations. The plan shall also  
50 30 integrate the requirements for annual reports by hospitals and  
50 31 health care facilities pursuant to section 135.75, the

50 32 provisions relating to analyses and studies by the department  
50 33 pursuant to section 135.76, the data compilation provisions of  
50 34 section 135.78, and the provisions for contracts for  
50 35 assistance with analyses, studies, and data pursuant to  
51 1 section 135.83.

51 2 d. An assessment of emerging trends in health care  
51 3 delivery and technology as they relate to access to health  
51 4 care facilities and services, quality of care, and costs of  
51 5 care. The assessment shall recommend any changes to the scope  
51 6 of health care facilities and services covered by the  
51 7 certificate of need program that may be warranted by these  
51 8 emerging trends. In addition, the assessment may recommend  
51 9 any changes to criteria used by the department to review  
51 10 certificate of need applications, as necessary.

51 11 e. A rural health resources plan to assess the  
51 12 availability of health resources in rural areas of the state,  
51 13 assess the unmet needs of these communities, and evaluate how  
51 14 federal and state reimbursement policies can be modified, if  
51 15 necessary, to more efficiently and effectively meet the health  
51 16 care needs of rural communities. The plan shall consider the  
51 17 unique health care needs of rural communities, the adequacy of  
51 18 the rural health workforce, and transportation needs for  
51 19 accessing appropriate care.

51 20 f. A health care workforce resources plan to assure a  
51 21 competent, diverse, and sustainable health care workforce in  
51 22 Iowa and to improve access to health care in underserved areas  
51 23 and among underserved populations. The plan shall include the  
51 24 establishment of an advisory council to inform and advise the  
51 25 bureau, the department, and policymakers regarding issues  
51 26 relevant to the health care workforce in Iowa.

51 27 4. The bureau shall submit the initial statewide health  
51 28 care delivery infrastructure and resources strategic plan to  
51 29 the governor and the general assembly by January 1, 2010, and  
51 30 shall submit an updated strategic plan to the governor and the  
51 31 general assembly every two years thereafter.

#### 51 32 DIVISION IX

#### 51 33 CERTIFICATE OF NEED PROGRAM

51 34 Sec. 33. Section 135.62, subsection 2, unnumbered  
51 35 paragraph 1, Code 2007, is amended to read as follows:

52 1 There is established a state health facilities council  
52 2 consisting of ~~five~~ seven persons appointed by the governor,  
52 3 ~~one of whom shall be a health economist, one of whom shall be~~  
52 4 ~~an actuary, and at least one of whom shall be a health care~~  
52 5 ~~consumer~~. The council shall be within the department for  
52 6 administrative and budgetary purposes.

#### 52 7 DIVISION X

#### 52 8 HEALTH CARE TRANSPARENCY

#### 52 9 DIVISION XXIII

#### 52 10 HEALTH CARE TRANSPARENCY

52 11 Sec. 34. NEW SECTION. 135.161 HEALTH CARE TRANSPARENCY  
52 12 == REPORTING REQUIREMENTS.

52 13 1. A hospital licensed pursuant to chapter 135B and a  
52 14 physician licensed pursuant to chapter 148, 150, or 150A shall  
52 15 report quality indicators, annually, to the Iowa healthcare  
52 16 collaborative as defined in section 135.40. The indicators  
52 17 shall be developed by the Iowa healthcare collaborative in  
52 18 accordance with evidence-based practice parameters and  
52 19 appropriate sample size for statistical validation.

52 20 2. A manufacturer or supplier of durable medical equipment  
52 21 or medical supplies doing business in the state shall submit a  
52 22 price list to the department of human services, annually, for  
52 23 use in comparing prices for such equipment and supplies with  
52 24 rates paid under the medical assistance program. The price  
52 25 lists submitted shall be made available to the public.

#### 52 26 EXPLANATION

52 27 DIVISION I == IOWA CHOICE HEALTH CARE COVERAGE PROGRAM.

52 28 Division I of this bill relates to the establishment of the  
52 29 Iowa choice health care coverage program with the intent to  
52 30 progress toward achievement of the goal that all Iowans have  
52 31 health care coverage with the following specified priorities:

52 32 1. The goal that all children in the state have qualified  
52 33 health care coverage which meets certain standards of quality  
52 34 and affordability by covering all children who are declared  
52 35 eligible for medical assistance, the state children's health  
53 1 insurance program, and hawk=i no later than January 1, 2011;  
53 2 subsidizing qualified health care coverage for the remaining  
53 3 uninsured children less than 19 years of age with a family  
53 4 income from 200 percent to less than 300 percent of the  
53 5 federal poverty level, under a sliding-scale contribution  
53 6 requirement based on family income no later than January 1,  
53 7 2011; and requiring all parents of children less than 19 years

53 8 of age to provide proof of qualified health care coverage for  
53 9 their children no later than January 1, 2011.

53 10 2. The goal of providing unsubsidized options for  
53 11 low-income adult Iowans with family income up to 400 percent  
53 12 of the federal poverty level to purchase qualified health care  
53 13 coverage.

53 14 3. The goal of decreasing health care costs and health  
53 15 care coverage costs by instituting health insurance reforms  
53 16 that assure the availability of private health insurance  
53 17 coverage for all Iowans by addressing issues involving  
53 18 guaranteed availability and issuance of insurance to  
53 19 applicants, preexisting condition exclusions, portability, and  
53 20 allowable or required pooling and rating classifications;  
53 21 requiring every child who has public health care coverage  
53 22 under a public program administered by the state or is insured  
53 23 by the Iowa choice health care coverage program to have a  
53 24 medical home; establishing a statewide telehealth system; and  
53 25 implementing cost containment strategies such as disease  
53 26 management programs, advance medical directives, initiatives  
53 27 such as end-of-life planning, and transparency in health care  
53 28 cost and quality information.

53 29 The Iowa choice health care coverage program (Iowa choice  
53 30 program) is established in Code chapter 514E under the  
53 31 authority of the Iowa comprehensive health insurance  
53 32 association (HIPIowa). The association is charged with the  
53 33 responsibility to assure that health benefit plans are made  
53 34 available to eligible individuals under the program and to  
53 35 prepare and submit a plan of operation for the Iowa choice  
54 1 program to the commissioner of insurance.

54 2 The Iowa choice program is established to provide access to  
54 3 qualified health care coverage to all Iowa children less than  
54 4 19 years of age, as funding becomes available, by enrolling  
54 5 all eligible children in medical assistance, the state  
54 6 children's health insurance program, and hawk=i no later than  
54 7 January 1, 2011; and by providing a premium subsidy using a  
54 8 sliding-scale contribution requirement to uninsured children  
54 9 with a family income up to 300 percent of the federal poverty  
54 10 level who are not eligible for enrollment in public programs,  
54 11 to purchase qualified health care coverage from the Iowa  
54 12 choice program, no later than January 1, 2011.

54 13 The bill also requires all parents of children less than 19  
54 14 years of age to provide proof of qualified health care  
54 15 coverage for their children no later than January 1, 2011.  
54 16 Implementation of this requirement may include a coverage  
54 17 reporting requirement on Iowa income tax returns or during  
54 18 school registration.

54 19 The association defines what constitutes qualified health  
54 20 care coverage for children. Policies issued through the Iowa  
54 21 choice program must include coverage and benefits specified in  
54 22 the bill. The association must establish a methodology to  
54 23 subsidize coverage for eligible children.

54 24 The association is authorized to develop an unsubsidized  
54 25 Iowa choice health care policy that is available for purchase  
54 26 by adults and families who are not eligible for a public  
54 27 program or subsidized coverage and have a family income that  
54 28 is less than 400 percent of the federal poverty level. This  
54 29 policy must include minimum benefits package options with  
54 30 premiums that do not exceed 6.5 percent of family incomes that  
54 31 are less than 400 percent of the federal poverty level.

54 32 Iowa choice health care policies shall be provided by  
54 33 private health insurance carriers and sold by licensed  
54 34 insurance producers that apply to the association and meet  
54 35 qualifications established by rules adopted by the  
55 1 association. The association shall collaborate with the  
55 2 carriers to design affordable, portable policies that meet the  
55 3 needs of eligible individuals.

55 4 The Iowa choice program may administer or contract to  
55 5 administer plans under section 125 of the Internal Revenue  
55 6 Code for employers and employees of employers with less than  
55 7 10 employees, including medical expense reimbursement accounts  
55 8 and dependent care reimbursement accounts.

55 9 The association may implement initiatives that make the  
55 10 purchase of health insurance coverage easier and decrease  
55 11 administrative costs and may perform various duties in  
55 12 administering the Iowa choice program, including designing and  
55 13 publishing an annual premium schedule.

55 14 The Iowa comprehensive health insurance association is  
55 15 required to submit an annual report to the governor and the  
55 16 general assembly regarding the Iowa choice program. The  
55 17 association may grant not more than two six-month extensions  
55 18 of the deadlines established for implementation of the program

55 19 as deemed necessary to promote orderly administration of the  
55 20 program and to facilitate public outreach and information  
55 21 concerning the program.

55 22 An Iowa choice health care coverage program fund is  
55 23 established in the state treasury under the control of the  
55 24 Iowa comprehensive health insurance association for the  
55 25 deposit of any funds for initial operating expenses of the  
55 26 Iowa choice program and any other funds that are received or  
55 27 appropriated to the program.

55 28 The department of human services is directed to expand  
55 29 coverage under the state children's health insurance program  
55 30 to cover children with family incomes up to 300 percent of the  
55 31 federal poverty level if sufficient funding is available and  
55 32 if federal reauthorization of the state children's health  
55 33 insurance program provides sufficient federal allocations to  
55 34 the state and authorization to cover such children as an  
55 35 option under the state children's health insurance program.

56 1 DIVISION II == CONTINUATION OF DEPENDENT HEALTH CARE

56 2 COVERAGE. Division II of the bill amends Code section 509.3  
56 3 to require a group policy of accident and health insurance to  
56 4 permit continuation of existing coverage for an unmarried  
56 5 dependent child of an insured or enrollee who so elects, until  
56 6 the dependent is 25 years old, or for as long as the dependent  
56 7 is a full-time student, whichever occurs last, at a premium  
56 8 established in accordance with the insurer's rating practices.

56 9 Division II also creates new Code section 514A.3B which  
56 10 requires an individual policy or contract of accident and  
56 11 sickness insurance to permit continuation of existing coverage  
56 12 for an unmarried dependent child of an insured or enrollee who  
56 13 so elects, under the same conditions as for group policies.

56 14 Division II applies to policies or contracts of accident  
56 15 and health insurance delivered or issued for delivery or  
56 16 continued or renewed in this state on or after July 1, 2008.

56 17 DIVISION III == BUREAU OF HEALTH INSURANCE OVERSIGHT.

56 18 Division III of the bill creates new Code section 505.8A  
56 19 establishing the bureau of health insurance oversight in the  
56 20 insurance division of the department of commerce. The bureau  
56 21 is created to promote uniformity and transparency in the  
56 22 administrative and operational business requirements and  
56 23 practices that are imposed by health insurers upon health care  
56 24 providers for the purpose of maximizing administrative  
56 25 efficiencies and minimizing administrative costs of health  
56 26 care providers that contract with or have other business  
56 27 relationships with health insurers.

56 28 The commissioner of insurance is required to establish a  
56 29 process for the filing, receipt, and investigation of  
56 30 complaints by health care providers regarding such  
56 31 administrative and operational requirements and practices of  
56 32 health insurers. Health insurers are required to file each  
56 33 contract offered to health care providers in this state with  
56 34 the commissioner at least 90 days prior to offering the  
56 35 contract.

57 1 The commissioner may convene representatives of health  
57 2 insurers, health care providers, and other interested persons  
57 3 to discuss ways to improve administrative or operational  
57 4 policies, processes, or practices of health insurers that  
57 5 affect health care providers. The commissioner shall identify  
57 6 such policies, processes, or practices that merit regulatory  
57 7 intervention or direction and take appropriate action. The  
57 8 commissioner may recommend legislation affecting such  
57 9 requirements and practices imposed upon health care providers  
57 10 to encourage uniformity, advance health insurer transparency  
57 11 of such requirements and practices, and lessen administrative  
57 12 costs. For the purposes of the new Code section, a health  
57 13 care provider is a physician licensed under Code chapter 148,  
57 14 150, or 150A.

57 15 DIVISION IV == MEDICAL HOME. Division IV of the bill  
57 16 relates to medical homes. The bill provides definitions,  
57 17 including the definition of a medical home which is a team  
57 18 approach to providing health care that originates in a primary  
57 19 care setting, and provides for continuity in and coordination  
57 20 of care. The bill specifies the characteristics of a medical  
57 21 home, and creates a medical home commission. The commission  
57 22 is directed to develop a plan for implementation of a  
57 23 statewide medical home system, to adopt standards and a  
57 24 process to certify medical homes based on national standards,  
57 25 to adopt education and training standards for health care  
57 26 professionals participating in the medical home system, to  
57 27 provide for system simplification, to recommend a  
57 28 reimbursement methodology and incentives for participation in  
57 29 the medical home system, and to coordinate efforts with the

57 30 dental home for children, and to integrate the recommendations  
57 31 of the prevention and chronic care management advisory council  
57 32 into the medical home system.

57 33 Implementation is to take place in phases, beginning with  
57 34 children who are recipients of medical assistance (Medicaid)  
57 35 and children who have health insurance coverage through the  
58 1 Iowa choice health care coverage program. The second phase  
58 2 would provide a medical home to adults under the IowaCare  
58 3 program, adult recipients of Medicaid, and adults covered  
58 4 through the Iowa choice health care coverage program. In  
58 5 addition to the phased-in implementation, the bill also  
58 6 directs the commission to work with the department of  
58 7 administrative services to allow state employees to utilize  
58 8 the medical home system, to work with the centers for Medicare  
58 9 and Medicaid services of the United States department of  
58 10 health and human services to allow Medicare recipients to  
58 11 utilize the medical home system, and to work with insurers and  
58 12 self-insured companies to allow those with private insurance  
58 13 to access the medical home system. The commission is directed  
58 14 to provide oversight for the medical home system and to  
58 15 evaluate and make recommendations regarding improvements to  
58 16 and continuation of the medical home system.

58 17 Division IV also amends provisions relating to the dental  
58 18 home for children under the Medicaid program to extend the  
58 19 date by which having a medical home for children is required  
58 20 from July 1, 2008, to December 31, 2010, and provides that the  
58 21 dental home is to provide the screenings and services required  
58 22 under the early and periodic screening, diagnostic and  
58 23 treatment program.

58 24 DIVISION V == PREVENTION AND CHRONIC CARE MANAGEMENT.  
58 25 Division V relates to prevention and chronic care management.  
58 26 The bill provides definitions relating to chronic conditions  
58 27 and chronic care and for the state initiative for prevention  
58 28 and chronic care management.

58 29 The division creates an advisory council to assist the  
58 30 director of public health in developing the state initiative.  
58 31 The advisory council is directed to elicit input from a  
58 32 variety of health care professionals, organizations, insurers,  
58 33 businesses, and consumers and is to submit initial  
58 34 recommendations to the director by July 1, 2009. The  
58 35 recommendations are to address the organizational structure  
59 1 for integrating chronic care management into the public and  
59 2 private health care systems, a process for identifying leading  
59 3 health care professionals and existing programs to coordinate  
59 4 efforts, prioritization of services directed to chronic  
59 5 conditions, a method to involve health care professionals in  
59 6 identifying individuals with chronic conditions, methods to  
59 7 increase communication between health care professionals and  
59 8 patients with chronic conditions, protocols and tools for  
59 9 health care providers to utilize, outcomes measures and  
59 10 benchmarks, payment methodologies and incentives, ways to  
59 11 involve public and private entities in facilitating and  
59 12 sustaining the initiative, alignment of information  
59 13 technology, involvement of health resources and researchers to  
59 14 collect data and evaluate the initiative, a marketing  
59 15 campaign, a means of determining participation in the  
59 16 initiative, a means to integrate chronic care management into  
59 17 education resources and curricula for existing and new  
59 18 education and training programs, and the establishment of a  
59 19 health and wellness strategies consortium.

59 20 The division provides that following initial  
59 21 recommendations and implementation among the eligible  
59 22 population of individuals (residents of the state who have  
59 23 been diagnosed with a chronic condition or who are at elevated  
59 24 risk for a chronic condition and who are recipients of medical  
59 25 assistance or IowaCare; an inmate of a correctional  
59 26 institution; or an individual who has qualified health care  
59 27 coverage through the Iowa choice health care coverage  
59 28 program), the director is required to work with various  
59 29 entities to implement the initiative as an integral part of  
59 30 the health care delivery system in the state.

59 31 The division also requires the director of public health to  
59 32 convene a clinicians advisory panel to advise and recommend to  
59 33 the department of public health clinically appropriate,  
59 34 evidence-based best practices regarding the implementation of  
59 35 the medical home and the prevention and chronic care  
60 1 management initiatives.

60 2 The division directs the department of administrative  
60 3 services to include in any request for proposals for the  
60 4 administration of health benefit plans for state employees a  
60 5 request for a description of any prevention and chronic care

60 6 management program provided by the entity offering the health  
60 7 benefit plan.

60 8 DIVISION VI == IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM.  
60 9 Division VI relates to the Iowa health information technology  
60 10 system. The division provides definitions, principles, and  
60 11 goals for the system. The division creates an electronic  
60 12 health information commission as a public and private  
60 13 collaborative effort and directs the commission to establish  
60 14 an advisory council to assist the commission in its duties; to  
60 15 adopt a statewide health information technology plan by  
60 16 January 1, 2009; to identify existing efforts and integrate  
60 17 these efforts to avoid incompatibility and duplication; to  
60 18 coordinate public and private efforts to provide the network  
60 19 backbone; to promote the use of telemedicine; to address the  
60 20 workforce needs generated by increased use of health  
60 21 information technology; to adopt necessary rules; to  
60 22 coordinate, monitor, and evaluate the adoption, use,  
60 23 interoperability, and efficiencies of the various facets of  
60 24 health information technology in the state; to seek and apply  
60 25 for federal or private funding to assist in implementing the  
60 26 system; and to identify state laws and rules that present  
60 27 barriers to the development of the health information  
60 28 technology system in the state.

60 29 The division requires that by January 1, 2010, all health  
60 30 care professionals utilize the patient identifier or  
60 31 alternative mechanism selected by the commission and the  
60 32 continuity of care record specified by the commission.

60 33 The division also provides that the Iowa hospital  
60 34 association is to be offered access to the Iowa communications  
60 35 network for the collection, maintenance, and dissemination of  
61 1 health and financial data for hospitals and for hospital  
61 2 educational services, subject to responsibility for all costs  
61 3 associated with becoming part of the network.

61 4 DIVISION VII == LONG-TERM CARE PLANNING AND PATIENT  
61 5 AUTONOMY IN HEALTH CARE. Division VII relates to long-term  
61 6 care planning and patient autonomy in health care. The  
61 7 division directs the department of elder affairs to consult  
61 8 with specified organizations to develop educational and  
61 9 patient-centered information on end-of-life care for  
61 10 terminally ill patients and health care professionals. The  
61 11 division also directs programs within the department of elder  
61 12 affairs and other appropriate agencies and interested parties  
61 13 to collaborate in recommending a public education strategy on  
61 14 long-term living. The division also directs the department of  
61 15 elder affairs in collaboration with the insurance division to  
61 16 implement a long-term care options public education campaign.  
61 17 The bill directs the department of elder affairs to work with  
61 18 other public and private agencies to identify resources to use  
61 19 to continue the work of the aging and disability resource  
61 20 center. The bill requires the department of public health to  
61 21 establish a two-year community coalition for patient treatment  
61 22 wishes across the health care continuum pilot project,  
61 23 utilizing the process based upon the national physicians  
61 24 orders for life sustaining treatment program initiative. The  
61 25 pilot may apply to the chronically ill, frail, and elderly or  
61 26 terminally ill individuals in hospitals, nursing facilities  
61 27 and residential care facilities, and hospices. The department  
61 28 is also to convene an advisory council to develop  
61 29 recommendations for expanding the pilot project statewide.  
61 30 The advisory council is required to hold meetings throughout  
61 31 the state to obtain input regarding the pilot project and its  
61 32 statewide application. Based on information collected, the  
61 33 advisory council is to report its findings and recommendations  
61 34 to the governor and the general assembly by January 1, 2010.  
61 35 The division provides for prioritization of documents relating  
62 1 to health care decision making and provides that in the  
62 2 absence of actual notice of the revocation of the document  
62 3 utilized under the pilot program, if actions are taken which  
62 4 are in accordance with reasonable medical standards, a  
62 5 physician, health care provider or other person may assert the  
62 6 provisions of the pilot program as an absolute defense against  
62 7 any assertion of criminal or civil liability.

62 8 DIVISION VIII == OFFICE OF HEALTH CARE QUALITY, COST  
62 9 CONTAINMENT, AND CONSUMER INFORMATION == BUREAU OF HEALTH CARE  
62 10 ACCESS. Division VIII creates the office of health care  
62 11 quality, cost containment, and consumer information and a  
62 12 bureau of health care access within the department of public  
62 13 health.

62 14 The bill requires the office of health care quality, cost  
62 15 containment, and consumer information to develop and implement  
62 16 cost-containment measures, provide for coordination of public

62 17 and private cost=containment, quality, and safety efforts,  
62 18 carry out other health care price, quality, safety-related  
62 19 research as directed by the governor and the general assembly,  
62 20 develop strategies to contain health care costs, develop  
62 21 strategies to increase the public's role and responsibility in  
62 22 personal health care choices and decisions, develop  
62 23 implementation strategies, develop a method for health care  
62 24 providers to provide a patient with a reasonable estimate of  
62 25 the charges for services, and identify the process and time  
62 26 frames for implementation of any initiatives.

62 27 The division directs the bureau of health care access to  
62 28 coordinate public and private efforts to develop and maintain  
62 29 an appropriate health care delivery infrastructure and a  
62 30 stable, well-qualified, diverse, and sustainable health care  
62 31 workforce in the state. One duty of the bureau is to develop  
62 32 a strategic plan for health care delivery infrastructure and  
62 33 health care workforce resources. The bureau is directed to  
62 34 establish a technical advisory committee to assist in the  
62 35 development of the strategic plan. The strategic plan is to  
63 1 include policies and goals based on specified principles, a  
63 2 health care system assessment and objectives component, a  
63 3 health care facilities and services plan to assess the demand  
63 4 for health care facilities and services, a health care data  
63 5 resources plan, an assessment of emerging trends in health  
63 6 care delivery and technology, a rural health resources plan,  
63 7 and a health care workforce resources plan. The initial plan  
63 8 is to be submitted to the governor and the general assembly by  
63 9 January 1, 2010, with an updated plan to be submitted  
63 10 biennially, thereafter.

63 11 DIVISION IX == CERTIFICATE OF NEED PROGRAM. Division IX of  
63 12 the bill relates to the certificate of need program by  
63 13 increasing the number of members of the state health  
63 14 facilities council to seven from five and by requiring that at  
63 15 least one member be a health economist, one an actuary, and  
63 16 one a health care consumer.

63 17 DIVISION X == HEALTH CARE TRANSPARENCY. Division X of the  
63 18 bill relates to health care transparency by requiring that  
63 19 hospitals and physicians report quality indicators, annually,  
63 20 to the Iowa health care collaborative. The indicators are to  
63 21 be developed by the collaborative. Additionally, the division  
63 22 directs manufacturers and suppliers of durable medical  
63 23 equipment or medical supplies doing business in the state to  
63 24 submit a price list to the department of human services,  
63 25 annually, for use in comparing prices for such equipment and  
63 26 supplies with rates paid under the medical assistance program.

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63 28 av:pf/rj/8